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PHARMACIST
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The Maryland
Pharmaceutical
Association

January, 1982
VOL. 58
NO. 1

1882 – 1982
MARYLAND
PHARMACEUTICAL
ASSOCIATION
SERVING THE PUBLIC HEALTH FOR 100 YEARS

Happy Birthday—MPh.A.

THE MARYLAND PHARMACIST

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JANUARY, 1982 VOL. 58 NO. 1

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President's Message

Remembering Where We've Been / Deciding Where We're Going

Remembering where we've been—deciding where we're going. This is a fitting theme for the January 1982 issue of the Journal of the Maryland Pharmaceutical Association. We are entering the second century of our existence. What an ideal time for reflection and resolution, for pondering and planning, for contemplation and commitment.

As in any year, many a pharmacist will adopt New Year's resolutions, but this year our profession has a special opportunity to enact particularly noteworthy policy resolutions to set the tone for the next centennial. I hope that the membership will give a great deal of thought to where they want to be in the future and recommend resolutions to the MPhA Resolution Committee. They will then format the resolutions and present them to the House of Delegates for consideration and adoption.

Back in 1882, the pharmacist spent a great portion of his time deciding what medications would be best for each patient and administering to their needs. In subsequent years we moved to the stage where the patients took their pains and problems to the physician. The physician in turn would provide the pharmacist with the directions for dispensing the appropriate prescription. The pharmacist would not have discussed the medical aspects of the medication with the patient for fear of violating the prerogatives of the physician. Now, we are one hundred years later at the dawning of clinical pharmacy. The pharmacist plays a major role in triage, the physician diagnoses and the pharmacist prescribes the regimen and monitors the patients' responses. Save for innovative technology, is this significantly different than it was a century ago? Have we made a complete cycle?

Many things have happened since the Association was formed on October 5, 1882, some 20 years before pharmacy laws were enacted in Maryland. We were established for the "mutual protection of pharmacists." We now need unity as much as ever, but for different reasons. The remaining issues of the MPhA journal will unveil many of the problems and triumphs that Maryland Pharmacists have had in the past. These same journals will provide documentation of where we.are and where we are going so that one hundred years from today, historian pharmacists will have the basis for meaningful analysis. A subsequent journal this year will carry a roster of our membership which will serve our needs today and document for posterity the names of those who feel that there is a need to support their profession. Those same individuals will receive a membership certificate commemorating our centennial. It is a one time issuance and I am sure it will prove to be a collector's item. There will be other memorabilia to add to our prized possessions as well as to present to others to have as cherished mementos.

Beyond this, we as pharmacists in the state of Maryland, during the 100th year of the Maryland Pharmaceutical Association have the unique opportunity and vehicle to promote our profession with earned pride. We will continue to grow (new members are joining at the greatest rate ever), we will continue to represent the pharmacists of this state at the legislature, professional seminars and educational programs will continue and pharmacists will stay informed through the Association on professional issues both statewide and nationally.

Philip H Cogan

Philip Cogan,
PRESIDENT

Maryland Pharmaceutical Association 1882-1982; Pharmacists in Maryland for 100 Years

The pharmacists of Maryland began to organize the Maryland Pharmaceutical Association in 1882. Called together in Baltimore from Cumberland, Hillsborough, Gaithersburg, and other areas of the state, seventy-three pharmacists were united to serve the public interest and improve their chosen profession.

As in the case of other health professions, in this period following the Civil War, the newly founded college faculty members contributed greatly to the new association. Most organized colleges of medicine, pharmacy, and dentistry were started in these formative days of our young Nation, so it is no surprise to learn the professors at the Maryland College of Pharmacy played a key role in the new organization.

In the 1880's, pharmacy associations were hindered by the same communications problems facing everyone. Travel was by train, by boat and by horse. Letters and other written communications were carried in the same manner.

Pharmacists of the 1880's were trained by the lecture method (a short term of a few weeks attending private lectures) and by the apprentice method (working for a practicing professional long enough to know the trade). The college laboratory of today was unknown because of the scarcity and expense of equipment.

Medicines in the 1880's consisted primarily of plant drugs, herbal remedies, a few patented med-

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icines, and individual concoctions of chemicals discovered, purified, measured and packaged in the back of the pharmacy or doctor's office.

The education of pharmacists was intertwined with their association with one another. Although the Maryland College of Pharmacy was organized in 1840 and began teaching in 1841 in Baltimore, its early promoters were physicians from the Eastern Shore of the State and Baltimore. Pharmacist Thomas G. MacKenzie permitted the lectures to be given in his office in the back of his store at Baltimore and Gay Street. Baltimore at this time boasted only 77 drug stores and the College started with six students. After holding classes in several locations there was an increase in the number of students, and by 1882 the merger of the College with the University of Maryland was first discussed. By 1886, a new building was constructed and occupied by the College, but the school did not become a department of the University until 1904.

The Maryland legislature, in 1882, had authorized the University to grant the degree of Doctor or Licentiate in Pharmacy to one who had served four years of apprenticeship, had attended two full courses of lectures in the theory and practice of pharmacy and one full course in qualitative analysis.

Meetings of pharmacists in the 1880's permitted them to continue their professional education, learn how to prepare new drug products, exchange sources of supply of ingredients and discuss business problems of the day. Travel methods prevented the frequent meetings that pharmacists are accustomed to today.

The first officers of the Maryland Pharmaceutical Association were John J. Thompson, president; John W. Geiger, secretary; and E. W. Russell, treasurer, all of Baltimore; but the outlying areas were represented by three vice-presidents, C. W. Crawford of Gaithersburg, Thomas W. Schryer of Cumberland, and Hugh Duffy of

J. Newton Gilbert

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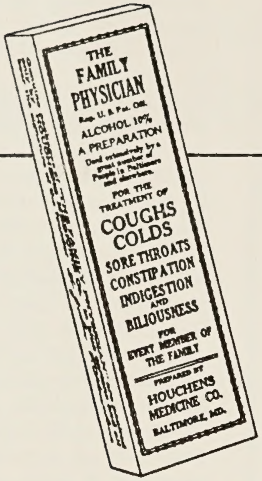

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Hillsborough. Having met at the College on October 5, 1882 with professor E. Eareckson as temporary chairman and professor C. Caspari as temporary secretary, they voted to meet again on May 8, 1883 and again on the second Monday of May, 1884.

From these modest first meetings, the Association continued its annual conventions and special programs throughout the year. After its first 50 years, the Association celebrated at Ocean City's Atlantic Hotel from June 21-24, 1932. At this meeting speakers represented two national pharmacy organizations, the U.S. Department of Commerce, the sister schools of medicine and dentistry, and others. Notably, a special reception was held for past presidents and charter members and to show appreciation to Dr. E. F. Kelly, who at this time was secretary of the Association, for 25 years of service. R. L. "Bob" Swain was then the editor of *The Maryland Pharmacist*.

At the 75th Anniversary, the Association met at Galen Hall in Wernersville, Pennsylvania, with 375 persons celebrating the event. Frank J. Macek was the outgoing association president and George M. Schmidt the incoming president. Joseph Cohen served the association as editor.

The present office of the Association was built in 1953 and named in honor of Dr. E. F. Kelly. It houses the business offices and the Dr. B. Olive Cole Pharmacy Museum, honoring Dr. Cole who served on the faculty of the College of Pharmacy from 1920 to 1953.

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If you wish to participate in this important Centennial Project, please make checks payable to the "M.Ph.A. Centennial Celebration Fund" and send to M.Ph.A., 650 W. Lombard St., Baltimore, Maryland 21201.

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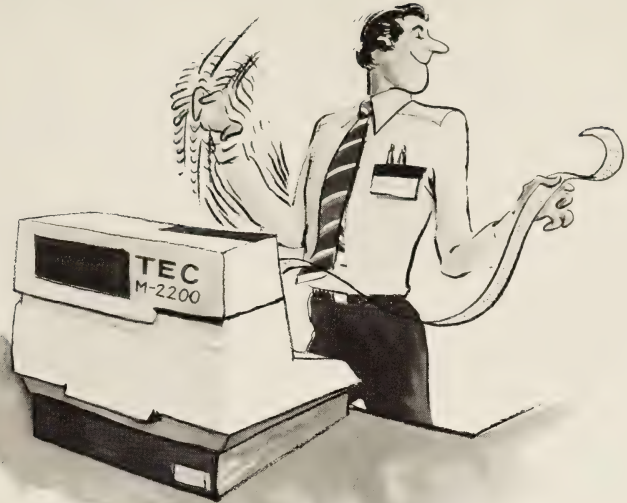

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Purified Insulins, What's the Difference?

by Marvin Oed, Pharm. B.S., P.D.

There has been considerable publicity as well as some confusion regarding the so-called purified insulins.

This article is not intended to be an exhaustive study of insulin differences, but should remove some of the confusion and enable the practitioner to make valid comparisons among the several insulin products available.

The purity of insulin can be compared in at least three different ways: the species source of the insluin, the modifiers used in the insulins and the pro-insulin content.

TABLE 1. INSULIN SOURCE

Manufacturer/Brand	Species Source
Lilly Iletin I (all)	Beef/Pork
Lilly Iletin II (all)	Beef
Lilly Iletin II (all)	Pork
Nordisk (all)	Pork
Novo—(all except Lentard)	Pork
Novo—Lentard only	Beef/Pork
Squibb*	Beef/Pork

* More highly purified and single species source insulins were about to be released as this article was being written and should be currently available.

Table 1 compares the source of the currently available insulins. Pork insulin is closer to human insulin than beef, differing in only one amino acid. Beef, being more abundant in the United States is more available and, therefore, less expensive than pork. If an individual is satisfactorily controlled, there is no reason to change insulin to that of a different source. A loss of control is possible and monitoring is suggested if a change is made. A change in species source might be indicated in those diabetics showing allergic reactions or insulin sensitivity.

Insulins have been modified in various ways to extend the duration of action and reduce the number of daily injections required. Zinc crystals, protein molecules and buffers are added to modify insulins for this purpose.

Table 2 compares the modified insulins. Regular and Lente insulins are the least antigenic because they contain no protein. In increasing order of antigenicity is globin, NPH and protamine zinc.

As with species source, there is no proven reason to change the stabilized diabetic from one modified insulin to another.

TABLE 2. MODIFIED INSULINS

	Insulin Type	Protein Modifier	Zinc/Buffer
I.	Regular Actrapid (Novo) Velosulin (Nordisk)	NO	NO
II.	Lente Semi Lente Ultra Lente Lentard (Novo) Monotard (Novo) Ultratard	NO	YES
III.	NPH Insulatard (Nordisk) Mixtard (Nordisk)	YES	NO
IV.	Protamine Zinc	YES	YES
	Globin	YES	YES

The real confusion began as Lilly introduced a more purified product (Iletin I) to replace Iletin and a highly purified product (Iletin II) along with two foreign manufacturers Novo and Nordisk introducing highly purified insulins.

There can be several contaminents in insulin. The FDA defines purity on the content of one of those contaminents, proinsulin. Any product containing less than 10 parts per million of proinsulin is considered to be purified insulin.

Table 3 compares the proinsulin content of the currently available insulins.

There is no conclusive evidence showing significant clinical benefit for the highly purified insulins in the well controlled diabetic.

TABLE 3. PURITY

Manufacturer/Brand	Pro-Insulin Parts Per Million FDA	Pro-Insulin Parts Per Million Other Source*
Lilly Iletin I	<50	<10
Lilly Iletin II Beef	<10	<10
Lilly Iletin II Pork	<10	<10
Squibb**	<10000	See footnote**
Novo	<10	<1
Nordisk	<10	Not detectable

* Other sources are manufacturers data or in-house manufacturing specifications.

** A new insulin containing not more than 25 ppm of proinsulin was due to be released as this article was being written. A highly purified insulin, not more than 9 ppm of proinsulin is to be released later in the year.

The FDA recommends that the use of purified insulin be primarily considered for patients in whom conventional insulins are not satisfactory. This patient population includes:

- Patients with local or systemic allergic reactions to conventional insulins
- Patients with lipidodystrophy caused by conventional insulin therapy

Those diabetics switched to purified insulin should be monitored to determine if a change in dosage is required.

It should be remembered that most patients use urine glucose levels to monitor therapy. Those levels may not correlate well with blood glucose levels. A patient showing negative and trace urine levels could be switched to a purified insulin and perhaps not be aware of a significant decrease in blood glucose. Monitoring of blood rather than urine levels is the way to avoid a potentially serious hypoglycemic reaction.

It would seem advisable that a diabetic expected to be on insulin for a short time be given the highly purified insulins to avoid sensitization should insulin be needed permanently in the future.

For the average diabetic, well controlled on conventional insulin, there seems to be no proven rational reason to change to the more expensive highly purified products.

If there are no problems in the well controlled insulin dependent diabetic, do not look for them by making a change. The newer insulins warrant a trial in the problem diabetic.

The Elder Ed Program at the University of Maryland School of Pharmacy has a new consumer pamphlet available entitled *"The Care Giver's Medication Guidelines."* The information presented is valuable to an individual who cares for an elderly family member or friend. For information contact: the Elder Ed Program, U. of Md. School of Pharmacy, 636 W. Lombard St., Baltimore, Md. 21201.

The Drug Product Selection Act

Effective July 1, 1979

Article 43—Health
Section 273A

(1) In filling a prescription for a brand name product, a pharmacist may dispense a different, lower cost, drug product of the same dosage form and strength if the different drug product is generically equivalent.

(2) The pharmacist may not select an equivalent drug product unless its price to the purchaser is less than the price of the prescribed drug product.

(3) Any pharmacist who selects an equivalent drug pursuant to this section incurs no greater liability in filling the prescription by dispensing the equivalent drug product than would be incurred in filling the prescription by dispensing the brand name drug prescribed.

The Department of Health and Mental Hygiene shall establish and maintain a drug formulary of equivalent drug products. The formulary:

(i) Shall list all drug products that the Commissioner of Food and Drug, United States Food and Drug Administration, has approved as safe and effective, and has determined to be therapeutically equivalent;

(ii) shall list all drug products that were not subject to premarketing approval for safety and effectiveness under the Federal Food, Drug and Cosmetic Act, are manufactured by firms meeting the requirements of that Act, are subject to Pharmacopoeial standards adequate to assure product quality, and have been determined by the Commissioner of Food and Drugs to meet any other requirements necessary to assure therapeutic equivalence; and

(iii) May list additional drug products that are determined by the Department to meet requirements adequate to assure product quality and therapeutic equivalence; and

(2) Provide for revision of the formularies are necessary but not less than every 6 months; and

(3) Provide for distribution of the formularies and revisions to all pharmacies and prescribers licensed in this state and to other appropriate individuals.

Department of Health and Mental Hygiene shall:

(1) Assess the need for public education regarding the provisions of this section;

(2) Provide for that education if appropriate; and

(3) Monitor the effects of this section periodically.

EDITOR'S NOTE

The Positive Formulary was recently mailed to all Pharmacies in the state. We are reprinting the DPS act as a reminder of the provisions in force for Drug Product Selection.

From the SBA

Getting the Facts for Income Tax Reporting

by William C. Greene
Certified Public Accountant, Wellesley, Massachusetts

Summary

When the facts are in proper order, Federal income tax reporting is greatly simplified. Proper recordkeeping procedures are the key to accumulating the information necessary for computing the return schedules and the tax. Although no specific records are required by the Internal Revenue Service, the owner-manager of a small business must be able to prove the statements made on the tax return. This paper gives suggestions on bookkeeping techniques that can affect taxes as well as simplify the task of accumulating necessary information.

April 15—Income Tax Day—is a mirror that reflects all the business days of the year for sole proprietors and partners. It is a confused reflection for some owner-managers of small firms because of poor recordkeeping. It is a clear reflection for other owner-managers because of good recordkeeping.

Day by day, week by week, and month by month, good records accumulate the facts you, the owner-manager, need for income tax reporting. These facts help you to report your income properly, to take proper tax deductions, and to back up that report should you be asked to do so.

No Set Records Required

The Internal Revenue Service [IRS] prescribes no specific accounting records, documents, or systems. However, the IRS requires that you maintain permanent books of account or records which can be used to identify your firm's income, expenses, and deductions. Where inventories are factors in determining income correctly, or when travel and entertainment deductions are taken, special supporting details are required.

Although IRS requires no particular form of records, your records must be accurate and reflect taxable income and allowable deductions. Records must also be kept so that they are available for inspection by IRS officers.

In most tax matters, the burden of proof lies with the taxpayer. Therefore, your records must reflect *all* your income and *all* your expenses, just in case they are inspected by an IRS agent. Otherwise, IRS may disallow any deductions which you have made and cannot substantiate. As a result, you may have to make an additional tax payment.

In addition, if you have adequate records, all the facts you need for filing a tax return are easily accessible. You are less likely to make a late filing for which there are severe charges and penalties. Moreover, you remove any suspicion of willful negligence and fraud for which a person can be fined or imprisoned.

A Simple System

If your small business is a sole proprietorship, you can use a simple set of records to capture facts for income tax reporting. Such a system consists of a check book, a cash receipts journal, a cash disbursements journal, and a petty cash fund.

Check Book. All funds that pass in and out of your store or service shop should go through a checking account which you set up for your business. (The owner-manager should handle personal expenses in a separate checking account.) When used with your other records, the check book helps you to prove how much money was handled, how much was taxable income, and what amounts were deductible for income tax reporting. You should reconcile your bank statement monthly, using the proof totals from your receipts and disbursements journals to check your work.

Cash Receipts Journal. All receipts should be entered in a receipts journal. In this manner, income that is not realized from sales—for example, advertising allowances—is separated from receipts that have to be reported as "gross receipts or gross sales." Sales taxes which you collect for the local or State government should also be kept separate because they are not business income.

Cash Disbursements Journal. All funds that are paid out should be recorded in a cash disbursements, purchases, and expense journal. The best practice is to enter daily in this journal each check you write. Each entry should show the nature or classification of the disbursement—merchandise, office supplies, rent, and employee wages, to mention a few examples. You can summarize the expense classifications by extending each entry into a column for a particular class of expenses and adding the columns monthly. This type of journal may be created by either posting each check stub regularly to a line in the journal or by using one of the "one-write" pegboards which are available from several commercial suppliers.

Petty Cash Fund. You should keep a petty cash fund with voucher slips to document each expenditure. In this manner, you can prove that cash expenditures—those of an amount too small to justify writing a check—are deductible for tax filing. A petty cash fund also eliminates your paying for miscellaneous small expenses out of your own pocket.

Other Records

Under even the simplest system, a fixed asset record is needed. In this manner, you record all equipment, buildings, vehicles, and other depreciable assets.

In addition, there is a variety of depreciation techniques such as accelerated methods and special "first year" additional depreciation which, in some cases, should be used to defer or reduce tax costs. (Investment credit applicability is also a factor. A good record of your assets is essential to plan for and get maximum tax advantages in these areas of fixed assets.) Under the Revenue Procedure 62-21, depreciation schedules and records must be kept for at least as long as the replacement cycle to substantiate the guideline lives which IRS allows.

Employers who withhold taxes from wages have to keep additional and extensive records. If you have one or more employees, you may be required to withhold Federal income tax from their wages. Your payroll records must include the amounts and dates of all employee wage payments subject to withholding taxes. You should keep such records for at least 4 years after the date the tax becomes due or is paid, whichever is later. (For additional details see "Steps in Meeting Your Tax Obligations," *Small Marketers Aids* No. 142, free from SBA, P.O. Box 15434, Fort Worth, TX 76119.)

Corporations and Partnerships. If your business is a small corporation or a partnership, your records must cover situations that do not exist in a sole proprietorship. In a corporation, the records must show the salaries paid to its officers and the dividends paid to stockholders. The owner-manager, as an officer of the corporation, is responsible for filing an income tax return for the company and a personal return to pay income tax on salary and dividends received from the corporation. If the business is a partnership, it files an information return on Form 1065 indicating the income or loss assignable to each partner. Each partner then files a personal return and includes his or her share of partnership income with his or her other taxable income. The legal form of your organization can have a substantial effect on taxes, and both legal and accounting advice will be important in selecting the best form of business for your particular needs.

Retaining Records

You should keep the records which you use to prepare your firm's income tax return. However, there is no fixed answer to the question of how long to retain such records. You should keep them as long as their contents may become material in the administration of any Internal Revenue law. Ordinarily, the statute of limitations for such records expires 3 years after the return is due to be filed.

Generally, the Internal Revenue Service cannot bring assessment or collection proceedings for a given taxable year after 3 years has elapsed from the due date of the return or the date it was filed, whichever is later. The major exception to this time period are in cases where the taxpayer omitted over 25 percent of gross income or filed a false or fraudulent return.

However, you should keep in mind that this 3-year period is a minimum. Many of your records should be kept for a longer period.

Among records often considered permanent are cash books, depreciation schedules, general ledger, journals, financial statements and audit reports. Records to be retained 6 to 7 years often include accounts payable and receivable, cancelled checks, inventory schedules, payroll records, and sales vouchers and invoice details.

Copies of income tax returns should always be retained. Retaining records helps the taxpayer as well as the IRS because it is often to the taxpayer's advantage to use carry-back claims and amended returns. In such cases, you must be able to prove that your tax returns are correct.

Plan with Records

As the owner-manager of a small business, you should use your records to plan your income tax. The government wants you to pay only your legal obligation—no more and no less.

This fact has been best expressed by the late Judge Learned Hand, who said, "Over and over again courts have said that there is nothing sinister in arranging one's affairs to keep taxes as low as possible. Everybody does so, rich or poor; and all do right, for nobody owes any public duty to pay more than the law demands."

Your accounting system should provide a current indication of the profitability of your business. Thus, your records help you to make a sound estimate of taxable income for the year, and consequently, the projected tax bracket of your business. You should review these figures at least once each quarter during the year to see what, if any, steps you can take to minimize your tax.

When making tax payments, it is essential that your accounting system provide a basis for your estimate. Where underpayment has already occurred, the system should substantiate the timing of income to avoid or mitigate penalties.

An employee benefit plan may offer tax advantages. For the smallest entrepreneur, the self-employed retirement deduction can be very beneficial. However, as in the case of any pension or profit sharing plan, the decision of whether or not to adopt such a plan or on what basis, depends on what your accounting system projects for profits and available cash.

Outside Help

Unless your background includes bookkeeping or accounting, you should use outside help in setting up your records. An accountant can help you determine what records to keep and what techniques will insure that you don't pay unnecessary tax.

For example, because of poor records one small owner unnecessarily included $30,000 of installment sales as taxable income even though they would not be earned for 2 or 3 years. At a 22 percent tax rate, more than $6,500 "extra" taxes were paid.

Inventory costing is another example of the need for sound records. Your records should allow you to substantiate a correct but minimum income valuation.

An accountant can also advise you on the most economical way of maintaining records. For example, some small businesses need only a part-time bookkeeper or can use a bookkeeping service. Still other firms need a full-time employee to keep records up-to-date.

In addition, accountants and lawyers can advise of changes in tax laws that may require adjustments in the kinds of facts necessary for tax reporting.

INDUSTRY RELATIONS COMMITTEE asks that Association members contact the Committee with information and examples of products that present dispensing difficulties. For example: package or container too small to label without covering necessary information; or product dilution information confusing or not legible, etc. The Committee will research the problem and may submit it to the USP and FDA's drug problem reporting system for correction. Call the office—(301) 727-0746.

History of the Drug House

THE DRUG HOUSE, INC. is the outgrowth of a retail drug store catering primarily to ships in the Port of Philadelphia, and started by John Smith in 1830. Expansion of his business eventually led to the formation of a wholesale drug business incorporated as Smith and Kline Company. Further expansion led to the change to Smith, Kline and French Company in 1891 and the Company operated under this trade name until 1929.

In the meantime, manufacturing of pharmaceutical specialties had become of such importance that separate divisions were established and, in 1929, Smith, Kline and French Laboratories became the parent Company and Smith, Kline and French, Incorporated became the wholesale subsidiary. The Company, in 1929, merged with Valentine H. Smith Company; in 1932, Miller Drug Company of Philadelphia; and in 1936 Aschenbach and Miller Company. In 1947, N. B. Danforth, Incorporated of Wilmington, Delaware and in 1952, Mercer Wholesale Drug Company of Trenton, New Jersey were purchased.

In 1951, Smith, Kline and French, Incorporated moved into the most modern and one of the largest wholesale drug warehouses in the United States. In 1956, a similar but smaller plant was erected in New Castle, Delaware, a suburb of Wilmington, and the Wilmington Division started operation in February, 1957.

Late in 1965, the Company was acquired from Smith, Kline and French Laboratories by the three sons of its former Chairman of the Board, J. Mahlon Buck. The new owners, who represent the fifth generation of the original Smith Family in the business, renamed it THE DRUG HOUSE, INC.

The Company began a period of rapid growth when in February, 1968, the operations of the Philadelphia Wholesale Drug Company were merged into those of THE DRUG HOUSE, INC. In May of 1972, the Company acquired all of the assets of Hensel & Sons, Inc. of Harrisburg, plus the Hensel Drug Co. of Johnstown.

In September of 1977, the assets of THE DRUG HOUSE were purchased by The Alco Standard Corporation, a major U.S. Corporation headquartered in Valley Forge, Pa. With the added strength of Alco behind the company, we were able to acquire the Baltimore Division of The Henry B. Gilpin Co. in July, 1979. The addition of the Baltimore Division has made your company one of the largest and most progressive full line, full service wholesale drug operations in the nation. It must be the company's aim, as well as the aim of every employee to provide our customers with the best service available.

When was the last time your insurance agent gave you a check . . . that you didn't ask for?

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Please contact me. I am interested in receiving more information about the Mayer and Steinberg/MPhA Workmen's Compensation Program. ☐ Call ☐ Write.

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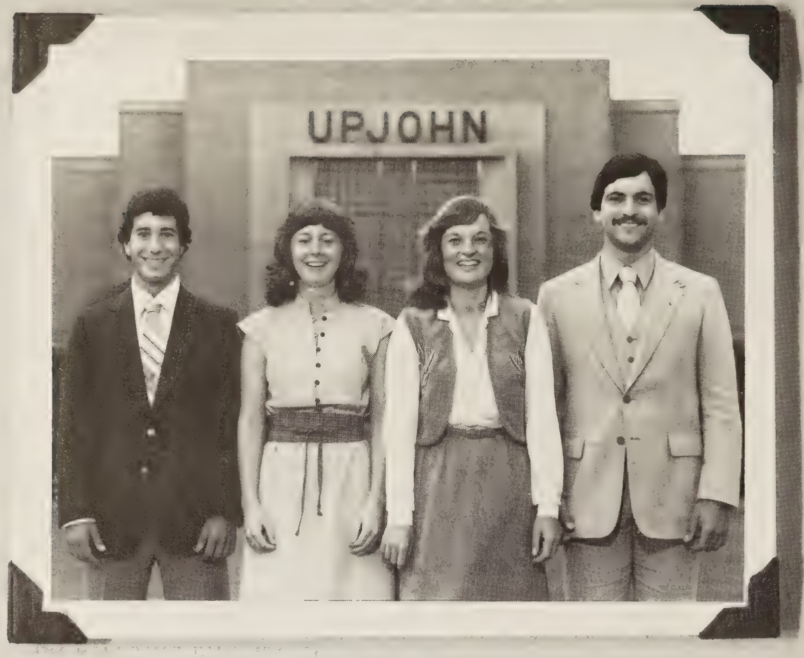

Robert J. Silverman	Jane M. Boone	Peggy M. Jones.	Michael K. Spray
University of Michigan	University of Wyoming	University of Wisconsin-Madison	Ferris State College

Remember the summer of '81?

Last summer, four young people joined The Upjohn Company as part of the NPC Pharmacy Internship Program.

They added to their educational process.... learned about manufacturing, quality control, pharmaceutical research, and marketing/sales.

We hope we answered their questions. Certainly, we took their suggestions to heart.

And when the 10 weeks were over, we parted knowing that we'll enjoy seeing each other in the years ahead.

And reminiscing about the summer of '81.

Upjohn

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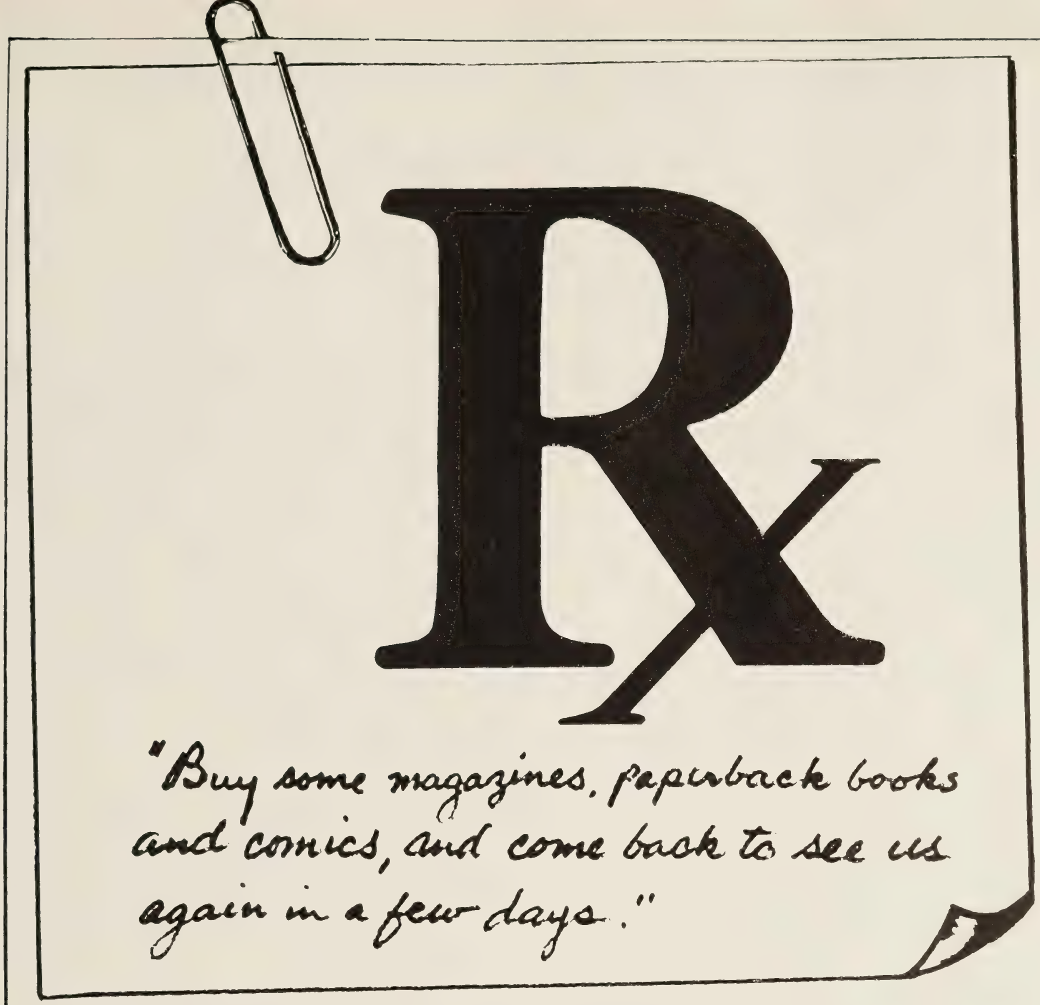
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Trafficking in Look-Alikes: An Update

Laurence B. Golden
Office of Intelligence
Drug Enforcement Administration

Recent federal and state actions have seriously affected the rampant trafficking in look-alikes that has been sweeping the country. Look-alike distributors, who began assaulting the nation with a blizzard of capsules and tablets early in 1980, and the manufacturers who supply them have been dealt a series of regulatory setbacks that may portend an end to this multi-million dollar industry.

Look-alikes are carefully designed to resemble or duplicate the appearance of brand name amphetamines, barbiturates, tranquilizers, and narcotic pain killers in both capsule and tablet form. On the street, they are known by the same names as their dangerous drugs counterparts: Black Beauties, Dexies, Yellows, Christmas Trees, and Rainbows. But look-alikes contain only noncontrolled substances such as caffeine, ephedrine, phenylpropanolamine, acetaminophen, and other over-the-counter non-prescription drugs.

As the number of mail order and store front wholesale distributors grew from a mere handful in early 1980 to more than 150 outlets by November of 1981, the production of look-alikes was reported to have soared to 30 million dosage units per week. During the past year and a half, the look-alike industry has flooded the nation's campuses and schoolyards with hundreds of millions of these pills. Intelligence derived from local police agencies, hospital emergency rooms, and medical examiners reveals widespread abuse, especially among teen-agers and college age youths.

In marked contrast to the methods used by illicit drug traffickers, look-alike distributors have conducted extensive advertising campaigns claiming their products to be both safe and legal. They have utilized full color brochures, magazine ads, highway billboards, and even television spots designed to appeal to teen-agers and young adults. Using commercial mailing lists, distributors have mailed colorful business cards directly to young recipients.

The easy availability of look-alikes has encouraged a climate of acceptance among many teen-agers and has conditioned them to the daily trafficking, handling, and consumption of these "pharmacal stimulants." In many places, look-alikes have become as much a part of the drug culture as the shopping center head shop and the paraphernalia vendor.

As the abuse of look-alikes grew, the public health dangers of these substances quickly became apparent. It is obvious that the young consumer who thinks that he has been purchasing "speed" or "ludes" and has become used to taking several look-alike capsules or tablets at a time in order to "get the full effect" runs the risk of serious overdose or death if one day he ingests the same number of real controlled substances. In addition to this danger, the look-alikes, themselves, can have serious damaging effects. The number of emergency room incidents attributable to these drugs has risen dramatically in the past year. More than a dozen deaths caused by look-alikes have been reported from around the country. More deaths from caffeine overdose and emergency room hypertensive incidents from severe reactions to phenylpropanolamine may have occurred but have gone unreported.

Although trafficking in look-alikes is not prohibited by the federal Controlled Substances Act, the Drug Enforcement Administration considers that the distribution and sale of look-alikes, as of drug paraphernalia, encourages and contributes to drug abuse and drug profiteering. The look-alike problem is one more facet of the nation-wide drug abuse problem. For these reasons, the DEA has undertaken a six-point program against look-alikes. Briefly stated, the six points are:

1. Drafting of a Model Imitation Controlled Substances Act[1] for concerned states to adopt.
2. Preparation of documentation describing the problem, distribution patterns and practices, and other information to be used in support of the Model Act.
3. Fostering intergovernmental agency cooperation and providing active support to other agency efforts.
4. Enlisting the support and voluntary cooperation of the legitimate pharmaceutical industry.
5. Publicizing the DEA initiative and encouraging the support of parent and community groups.
6. Targetting of states heavily involved in look-alike distribution and manufacture to encourage legislative action.

More than a dozen states have enacted or are considering legislation targetted against the manufacture and distribution of look-alikes. States with legislation now on the books include Arkansas, Colorado, Conneticut, Delaware, Florida, Indiana, Kansas, Louisi-

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[1] Copies are available upon request from the Dangerous Drugs Section, Office of Intelligence, Headquarters, DEA.

ana, Maryland, North Carolina, Oklahoma, Oregon, and South Dakota. Some cities, such as Independence, Missouri, have passed local ordinances prohibiting storefront look-alike sales. In other state action, the Attorney General of Illinois has filed complaints against 39 look-alike distributors. To date, he has obtained verbal agreements from 15 distributors to cease and desist selling in the State of Illinois and he has obtained temporary restraining orders against three others.

The legitimate pharmaceutical industry also has been cooperating in efforts to eliminate the look-alike problem. The Eli Lilly Company, one of the largest manufacturers of gelatin capsules, has, since July 1981, refused to sell capsules to look-alike manufacturers. Other capsule manufacturers also have indicated a willingness to cooperate in this effort. The resulting lack of capsules already has begun to affect the look-alike distribution chain and some distributors say they can no longer obtain "Yellows" and "Black Beauties."

Recent actions by federal government agencies are having salutary effects on the problem too. During the past several months, the U.S. Postal Service has filed complaints against 39 look-alike distributors. To date, the Postal Service has concluded consent agreements with nine distributors and has obtained False Representation Orders against nine others. The False Representation Orders require postmasters to stop the delivery of all mail to the subject distributors.

The most significant federal action yet taken occurred on September 30, 1981, when the Food and Drug Administration filed counterfeiting and mis-labeling complaints against nine manufacturers of look-alike drugs. With the assistance of U.S. Marshalls in five states, seizures of equipment, materials, and finished products were effected at the following locations:

BT Pharmaceuticals, Inc.
Tampa, Florida

Frye Pharmaceuticals, Inc.
Birmingham, Alabama

Jerome Stevens Pharmaceuticals, Inc.
Central Islip, New York

Valley Run Pharmaceutical
Milroy, Pennsylvania

Newtron, Pharmaceuticals, Inc.
Coram, New York

Pharmadose, Inc.
Bohemia, New York

Standard Pharmacal Corp.
Elgin, Illinois

LNK International, Inc.
Hauppauge, New York

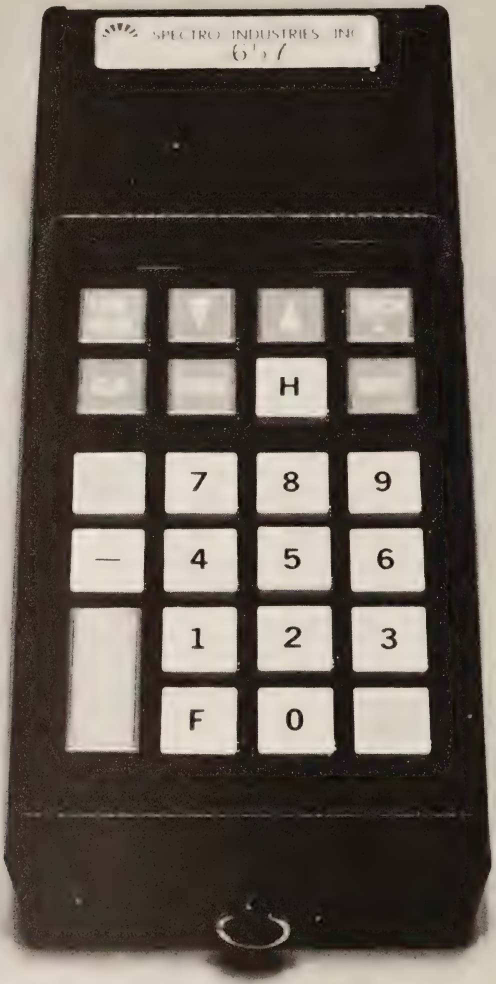
VIP Pharmaceuticals, Inc.
Pearl River, New York

An inventory of seized items includes: 15 million filled capsules, 800,000 tablets, 20 million empty capsules, and over one million dollars worth of equipment including offset rollers, capsule printers, tablet punches and dies, and tablet presses. The FDA felt that its case against a tenth manufacturer, Ketchum Laboratories of Amityville, New York, was inadequate to support any enforcement action at that time.

As a result of the FDA actions, one of the manufacturers has already signed a consent agreement to cease and desist production of look-alikes, and two more companies are also negotiating consent agreements. Information on responses by the other manufacturers was unavailable as of the date of this report.

The actions described above comprise a promising start toward ending the nation-wide trafficking in look-alikes. It is too early to make an accurate evaluation of the overall damage suffered by look-alike traffickers, but there is room for some optimism. Continuing action by federal agencies, state and local governing bodies, the pharmaceutical industry, and the public will be required to eliminate the look-alike problem from this country.

If our new Order Entry System doesn't save you time and money within 60 days, you don't owe us a dime for the system.



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(215) 885-3676

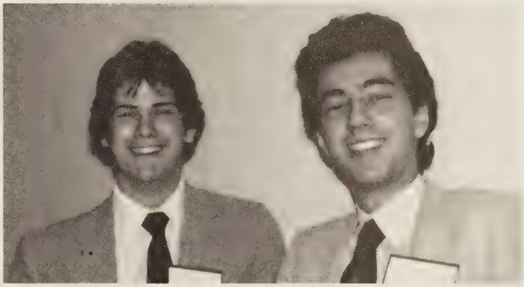
M.Ph.A. President Philip Cogan presented a comic monologue as part of the Fall SAPhA Coffeehouse.

Held on November 13, 1981 at the Kelly building, the Coffeehouse starred pharmacy school talent.

Anne Myers performed for the overflow crowd.

SAPhA uses the Coffeehouse as a fundraiser for its many other activities.

Maryland was well-represented at the Regional meeting of SAPhA in New Jersey. As a result, next year's Regional meeting will be held in Baltimore.



Brian Sanderoff (left) and Taher Sheybani (right) both ran for office at the Regional Meeting.

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"Firsts" for the School of Pharmacy

- The first school of pharmacy in the South.
- The first Baltimore professional school to place all faculty members on salaries.
- The first University of Maryland school to require written entrance examinations.
- The first separate course in pharmacy offered in the United States.
- The first separate professorship in the theory and practice of pharmacy in the United States.
- The first school of the University to occupy a building purchased by its alumni.
- The first laboratory for physiological drug testing in America.
- The alma mater of the author of the first scientific paper read before the American Pharmaceutical Association.
- The first obligatory American pharmacy school courses in analytical chemistry and prescription compounding, and the first full-time pharmacology department, as well as professorships in these areas.
- The first school to convene representatives of pharmacy schools to formulate uniform standards for the graduation of students which resulted in the formation of the present American Association of Colleges of Pharmacy.
- The first to offer extensive training in patient assessment skill to Doctor of Pharmacy students.
- The first structured Professional Experience Program, an externship for students that involves practical work experiences in community, hospital and institutional pharmacies.
- The first accreditation conference on pharmacy schools which led to the establishment of the American Council on Pharmaceutical Education.
- The first central nuclear pharmacy in Maryland.

APhA '82 LAS VEGAS

Stock up on Ipecac!!

Jacquelyn S. Lucy, M.A., M.Ed.
Coordinator, Education/Communications
Maryland Poison Center

Again this year, the Maryland Poison Center, a division of the University of Maryland School of Pharmacy, will be promoting Syrup of Ipecac as part of its observance of Maryland Poison Prevention Week (MPPW) (March 14-20, 1982). Last year's MPPW success was due largely to the efforts of pharmacists throughout the state who sponsored displays, contests, programs, etc. to help in the on-going fight against accidental poisonings. This year's campaign will again call on pharmacists. The focus for the 1982 MPPW will be built on increasing the general public's awareness of common medicines (aspirin, tylenol, cough and cold preparations, laxatives, liniments, etc.) as potential poisons. In 1980 (most current data available), medicines ranked as the number one poisoning agent for every age group except those less than one year of age where it ranked second after plants. Since adults must be aware that an item is harmful before they will keep it out of reach, MPPW will concentrate on over the counter drugs frequently involved in childhood poisonings. During MPPW, the Maryland Poison Center encourages pharmacists to help increase their public's awareness of OTC products: their proper use, storage and dangers associated with misuse either alone or in combination with other drugs. Hopefully, awareness of medicines as possible poisoning agents will lead to preparedness in case of an accidental exposure. The best preparation involves having the number of the Maryland Poison Center on the telephone and a one-ounce bottle of Syrup of Ipecac in the home. According to preliminary data for the first six months of 1981, 91% of the calls involving children under 5 were treated at home. Frequently, this treatment involved the administration of Ipecac Syrup. Thus, the Maryland Poison Center encourages you to recommend Ipecac Syrup for all your clients with small children.

Another important feature of Maryland Poison Prevention Week is programming. If you conduct or are willing to conduct programs on poison prevention in your community, please contact Jacquie Lucy at (301) 528-7184 to register for the MPC speaker's bureau.

Announcing the Reactivation of the

EMPLOYEE—EMPLOYER RELATIONS FORUM

The purpose of the Forum is to deal creatively with the issues in Maryland Pharmacy employer and employee relations. This Committee of the Association is made up of individuals from a wide variety of practice settings. We are asking for input on current employment issues from all segments of the profession. The Forum will act as a "sounding board" on these issues and will provide some ombudsman activity.

1882 — 1982
SERVING THE PUBLIC HEALTH FOR 100 YEARS
MARYLAND PHARMACEUTICAL ASSOCIATION

We are asking for your help in submitting issues to the Forum for comment and response. If you have a suggestion, idea, or comment, contact the Employer/Employee Relations Forum at: 650 W. Lombard St., Baltimore, Md. 21201.

The reactivation of the Employer—Employee Relations Forum coincides with the Association's Centennial. The Committee decided that there are many favorable sentiments about the profession of pharmacy and what it means to members that are often left unspoken. During the Centennial year members are asked to express in a positive way what pharmacy means to them. Here is one such sentiment:

"As we enter the year of the MPhA Centennial, the following sentiments express my pride in our profession, PHARMACY:

P is for *pharmacists.* And for our *patients* and *patrons,* the *people* for whom we dispense *prescriptions* and for whom we recommend and sell *products* for their health and well-being.

H is for *health* profession. As pharmacists, we have the responsibility to counsel and caution our patrons, the public, on the safe and effective use of drugs and other products.

A is for *answers.* We continue to update our knowledge and stand ready to provide easily understood answers and information to educate the public and other health professionals.

R is for *reponsibility.* We are working within our associations and the community to benefit society in controlling drug abuse, misuse, and for the improvement of health care.

M is for *membership.* Increasing numbers of pharmacists are achieving self-satisfaction by becoming active members in their associations, participating at meetings, volunteering on committees, striving for unity of purpose.

A is for *achievement.* From the achievements of the pharmaceutical industry to all of us who work daily with the fruits of these achievements, we provide what I believe is the best pharmacy care in the world to our patients and patrons.

C is for *care,* the care and attention we give to our patients and our duties and to putting our ideals and principles into practice.

Y is for *younger* pharmacists who have many great opportunities, now and in the future, to work with fine colleagues and associations to build an even more rewarding profession."

Centennially Yours,
Edward Nussbaum, P.D.

LETTERS

In an effort to control the theft and forgery of St. Agnes Hospital prescription blanks, we have revised both their format and procedure for use.

Effective December 1, 1981, we will replace the present yellow St. Agnes Hospital blanks with two new blanks.

> A blue prescription blank marked "NOT VALID FOR CONTROLLED SUBSTANCES" which will be used *ONLY* for non-controlled drugs.
>
> A pink prescription blank marked "VALID FOR CONTROLLED SUBSTANCES ONLY." These blanks will be serial numbered and contain space for the physician's DEA number. *ONLY* controlled drugs in Schedule II, III, IV, and V are to be written on these blanks.

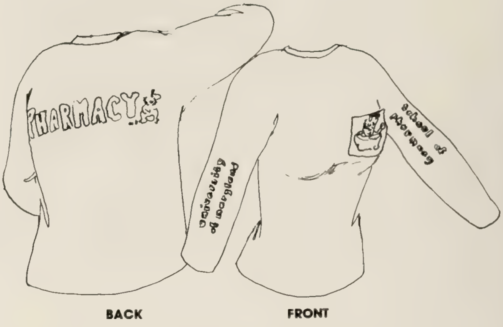
Records will be maintained in the Pharmacy Department of the serial numbers of the controlled blanks and the area within the hospital to which they are given.

Please note that when we begin to use the new pink and blue St. Agnes Hospital blanks, there will be a number of old yellow blanks still in the hands of some of our patients who have not had the chance to have them filled. We therefore request that the community pharmacists exercise professional judgement during the phase in period.

Bernard Fischer
Pharmacy Director
St. Agnes Hospital

Baltimore Radio Stations WCAO-AM and WXYV-FM were recently honored by the Association for their continuing support of the Association's public information programming. (left to right) Larry Wilson, Joseph Cahill and Ron Riley from the station receive the special award presentation from Charles Spigelmire (far right).

ORDER YOUR PHARMACY T-SHIRTS TODAY



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Supported by the Maryland Department of Health and Mental Hygiene under NHLBI contract NO 1-HV-7-2986

Newly installed BMPA President Frank Marinelli presided over the annual membership meeting of the Association held on November 5, 1981.

Dr. Warren M. Ross from the Union Memorial Hospital Fitness Center discussed stress and lifestyle at the BMPA meeting.

Wesley Frisbie, Technical Director of Respiratory Therapy at St. Joseph's Hospital was one of the presentors at the Continuing Education Coordinating Council's program on Pulmonary Disease.

The C.E. program was held November 15th at the Baltimore Airport. Marvin Oed, Clinical Assistant Professor at the School of Pharmacy, led the workshop on non-drug management.

Harvey Lybolt, a registered Respiratory Therapist discussed various equipment used to treat pulmonary disease. The Seminar was designated the Henry Siedman Memorial Lecture.

Dr. Susan Bollinger, Director of Respiratory and Pulmonary Medicine at Carroll County General Hospital presented a discussion of chronic lung disease.

ABSTRACTS

Excerpted from PHARMACEUTICAL TRENDS, published by the St. Louis College of Pharmacy; Byron A. Barnes, Ph.D., Editor and Leonard L. Naeger, Ph.D., Associate Editor

BARBITURATES:

The molecular mechanism of action of general anesthetics, local anesthetics and barbiturates seem to have similar characteristics. It appears as if barbituric acid derivatives act as the anion to block the sodium channels of the neuron, but not in a manner identical to that produced by the anesthetic agents. Much of this work in neuronal pharmacology is being carried out using tissue obtained from frogs. *J Pharmacol Exp Ther,* Vol. 218, #1, p. 175, 1981.

BIGUANIDES:

Although it has become increasingly difficult to obtain phenformin (D.B.I.) and other biguanides used in the treatment of diabetes mellitus, research into the mechanisms of action of these compounds continues. These drugs do not act on the pancreas as do the oral sulfonylureas, but are thought to exert their hypoglycemic activity by increasing muscle uptake of glucose, decreasing gluconeogenesis, decreasing intestinal absorption of glucose, increasing anaerobic glycolysis, and altering membrane-surface potentials in a positive direction. Such agents require the presence of some insulin in order to be effective and they rarely produce hypoglycemia. Recent studies suggest that the biguanides also act by increasing the sensitivity of body cells to insulin. This increased sensitivity seems to follow a drug-induced increase in the number of insulin receptors which are found on cell-surface membranes. *N Engl J Med,* Vol. 305, #10, p. 563, 1981.

AMINOPHYLLINE:

Aminophylline is one of many methylxanthine derivatives used to treat asthma and related conditions. It is well known that aminophylline will increase respiratory capacity by dilating the bronchioles, but recent work indicates that it is also capable of increasing the contractability of the diaphragm thus improving overall respiratory function. *N Engl J Med,* Vol. 305, #5, p. 249, 1981.

JET LAG:

Jet lag, a condition common to long distance travelers, is thought to be due to alterations which occur in diurnal variation or circadian rhythm, brought on by movement along different longitudes within a short time. The area of the brain where this biological clock resides has been determined. Investigators feel it exists in the supra chiasmatic nucleus within the central nervous system. *J Am Med Assoc,* Vol. 246, #6, p. 681, 1981.

METABOLIC ACTIVITY IN THE LINING OF THE GASTROINTESTINAL TRACT:

Some drugs have been found to be metabolized as they pass through the gastrointestinal mucosa thus reducing the amount of active drug which enters the blood stream after oral administration. Drugs such as ethanol, flurazepam (Dalmane), and tyramine are oxidized by the tissue while hydrolysis of aspirin and pivampicillin has been recorded in the same areas. Estrogenic substances are glucuronidated and sulfation of various catecholamines and catecholamine-like substances has been observed. N-acetylation and methylation are also known to occur. Among the drugs which are metabolized to some extent as they pass through the gastrointestinal mucosa are metoclopramide (Reglan), imipramine (Tofranil), isoniazid, hydralazine (Apresoline), chlorpromazine (Thorazine), and spironolactone (Aldactone). *Clin Pharmacokinet,* Vol. 6, #4, p. 259, 1981.

VENTRICULAR ARRHYTHMIAS:

Life-threatening ventricular arrhythmias are induced by various stimuli, but a retrospective study of 117 patients has shown that 25 people experienced acute emotional disturbances within 24 hours of developing the arrhythmia. The role of the central nervous system in the development of cardiac arrhythmias may have been underestimated. *J Am Med Assoc,* Vol. 246, #3, p. 233, 1981.

QUINIDINE/DIGOXIN INTERACTION:

Quinidine has been found to displace digoxin from tissue binding sites thus enhancing activity of the glycoside. These sites are not associated with the Na^+-K^+-ATPase enzyme acted on by the glycoside. A strict structural requirement is present for the interaction as propranolol, verapamil, and lidocaine do not have the ability to increase digoxin plasma levels. *J Pharmacol Exp Ther,* Vol. 218, #2, p. 357, 1981.

SMOKELESS TOBACCO:

There is a tendency today to use snuff or smokeless tobacco instead of smoking cigarettes. Some feel it is completely safe to substitute the smokeless tobacco for the more conventional material but studies show that the levels of nicotine and cotinine found in the plasma of snuff users is comparable to that seen in cigarette smokers. Since cigarette smoking is considered to be physiologically addicting, it must be recognized that smokeless tobacco may not produce the respiratory complications produced by cigarette smoking, but it is likely to be habit forming and thus should not be considered harmless. *Clin Pharmacol Ther,* Vol. 30, #2, p. 201, 1981.

PHYSOSTIGMINE AND MORPHINE:

The major effects of morphine include analgesia, respiratory depression, bradycardia, and hypotension. It has been postulated that the respiratory and cardiovascular effects of the narcotics are mediated through inhibition of the release of acetylcholine from neurons in the central nervous system. To investigate this possibility, physostigmine was administered after the effects of the narcotic were evident. Physostigmine, a tertiary amine with the ability to inhibit acetylcholinesterase centrally, reversed the effects of the narcotic on the respiratory and cardiovascular system without altering the analgesic effect. This helps support the concept that cholinergic receptors are involved in some of the actions produced by the narcotics. *J Pharmacol Exp Ther,* Vol. 218, #2, p. 504, 1981.

VIPERGIC NERVES:

Vasoactive intestinal prolpeptide (VIP) is a regulatory peptide composed of 28 amino acids. It relaxes smooth muscle in the arterioles and thus acts as a potent vasodilator. It is found in the autonomic nerve fibers supplying many peripheral tissues and has been termed a non-cholinergic, non-adrenergic transmitter. VIP has been called a peptidergic transmitter. The male genital tract seems to be extremely rich in these fibers and thus VIP may play a role in nervous control of external genitalia. *Lancet,* Vol. II, #8240, p. 217, 1981.

HYPERGLYCEMIA:

Animals were injected with streptozotocin, a product used to produce experimental pancreatic damage and subsequent hyperglycemia. Animals thus treated were found to experience greater response to morphine and other analgesics while animals with induced hypoglycemia were affected in the opposite direction. The effect is thought to be mediated through central mechanisms since pharmacokinetic parameters of morphine were not different in the treated animals as compared with those used as controls. *J Pharmacol Exp Ther,* Vol. 218, #2, p. 318, 1981.

ALCOHOL INGESTION:

Over 2000 patients were placed into one of four groups matched for age, sex, race and cigarette smoking habits. Their alcohol ingestion and mortality rates were recorded over a ten year study period. Those who reported light drinking habits, (approximately 2 drinks per day) had the lowest mortality rate. Non-drinkers and those who used 3 to 5 drinks/day had a mortality rate 50% higher than the former group, and heavy drinkers had the highest mortality rating. Heavy drinkers died of cancer, cirrhosis, accidents, and non-malignant respiratory conditions while non-drinkers died most frequently from coronary disease. Smoking increased the likelihood of death due to cancer and non-malignant respiratory disease. *Ann Inter Med,* Vol. 95, #3, p. 139, 1981.

PHENOBARBITAL:

Approximately half of the prematurely born infants with birth weights of less than 1500 grams are found to have experienced periventricular or intraventricular hemorrhage. Infants in this category were treated with intravenous phenobarbital in doses sufficient to produce anticonvulsant activity. This treated group experienced only a 13.3% incidence of hemorrhage thus reflecting a beneficial effect of the barbiturate therapy. Various mechanisms have been postulated to explain this effect. *Lancet,* Vol. II, #8240, p. 215, 1981.

MOUNTAIN SICKNESS:

Experience with mountain climbers indicate that nearly 5% of those ascending the peaks suffer from a severe form of cerebral or pulmonary edema and half of those involved in the sport will experience headache, weakness, nausea, or vomiting. This is especially true when they climb at altitudes above 14,000 feet. Hypoxia and alkalosis are frequently seen and are thought to be closely associated with the development of these symptoms. The use of diuretics alone (furosemide-Lasix, spironolactone-Aldactone) is not effective in protecting against the development of systems, but acetazolamide (Diamox) is beneficial in that it helps remove fluid and at the same time keeps the plasma from becoming severely alkalotic. It is best used prophylactically and does little to help a patient with established problems. One must be careful not to ascend too rapidly because symptoms will appear regardless of precautions taken. *Br Med J,* Vol. 283, #6288, p. 396, 1981.

AMIODARONE:

Another antiarrhythmic agent has been utilized orally to help stabilize abnormal ventricular rhythms. The side-effects include corneal microdeposits, hyperthyroidism, blue skin, nausea and bradycardia. Adverse reactions to amiodarone were noted frequently, but they usually did not limit therapy. Amiodarone has been used for several years in other countries. *N Engl J Med,* Vol. 305, #10, p. 539, 1981.

RECEPTOR ALTERATIONS:

Chronic administration of beta-adrenergic agents can lead to reduced activity of the receptors by two different mechanisms. Heterologous desensitization is due to a reduction in the synthesis of cyclic AMP, while homologous desensitization is associated with a loss of beta-adrenergic binding sites. Oxotremorine is a drug which acts on the cholinergic receptor with great intensity. Chronic administration of this agent reduces the number of muscarinic receptors in the cholinergic nervous system and thus leads to the development of tolerance via homologous desensitization. *J Pharmacol Exp Ther,* Vol. 218, #2, p. 337, 1981.

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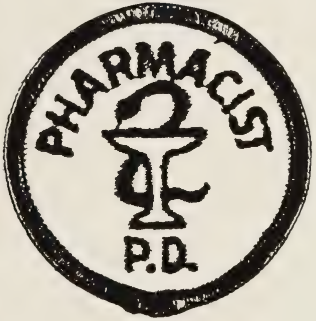
- these and many other services, contact Beverly at the MPhA Office (301) 727-0746.

The Elder Ed Program at the University of Maryland School of Pharmacy has a new consumer pamphlet available entitled *"The Care Giver's Medication Guidelines."* The information presented is valuable to an individual who cares for an elderly family member or friend. For information contact: the Elder Ed Program, U. of Md. School of Pharmacy, 636 W. Lombard St., Baltimore, Md. 21201.



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calendar

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Feb. 14—BMPA Dinner-Dance, Blue Crest
April 24-29—APhA Convention, Las Vegas
March 14 (Sunday)—Alumni Association Dinner Meeting
June—Maryland Society Hospital Pharmacist, Seminar Williamsburg
June 20-24—MPhA Centennial Convention, Ocean City

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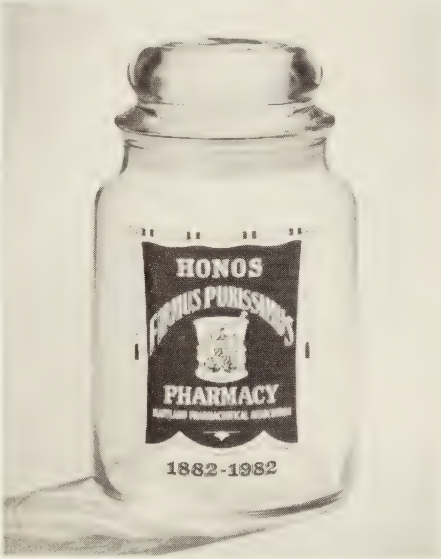

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THE
MARYLAND
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Official Journal of
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February, 1982
VOL. 58
NO. 2

David Stewart, First Professor of Pharmacy in America

— Ben Allen, Ph.D.

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President's Message

Recently, Dr. Farmer, Chancellor of the University of Maryland, Baltimore Campus, requested a meeting with representatives of your Association's Board of Trustees. At issue was the future of the Kelly Memorial Building, headquarters of the Maryland Pharmaceutical Association. Our building is on the Campus of the University. We were told that University planners would like to expand the capacity of the University Hospital, including the shock-trauma facilities. As health care practitioners, we should understand this need and support the addition. Maryland's unique and efficient state-wide system for handling shock-trauma would be compromised if the Hospital could not expand. Unfortunately for us, our building is in the path of any new addition. We are optimistic, however, that our Association headquarters operation will not be jeopardized in the process of construction.

Due to the foresight of the pharmacists who built the Kelly Memorial Building in 1953, sold it to the University for $1.00 and in return received use of it for 99 years, we find ourselves in a favorable position. They did an excellent job of not only designing the building, but also providing for the future of the profession by their creative handling of the property itself.

Chancellor Farmer, who has an appreciation for the history of pharmacy in Maryland says he feels compelled to support the interests of the State's pharmacists, who themselves have fostered the cultivation of the history of Maryland pharmacy. For those of you who have not visited your headquarters, I'm sure you too would be impressed with the museum, the large show globe and mortar and pestle collections, as well as the other precious artifacts.

At this time, we are waiting for the University to provide us with alternatives for our headquarters' facility. Options may include moving the Kelly Memorial Building, sharing a building, or constructing a new single unit building, depending upon the costs involved and the appraised value of our building. Of course, any major University capital expenditure must be appropriated by the State Legislature. We have been told that the issue will be decided this legislative session. If the issue is defeated, it is our understanding that the University will not seek authorization to expand the hospital in the foreseeable future. On the other hand, if the request is approved, the Association will have to be prepared to move on relatively short notice. I bring this issue to your attention so that the membership, particularly our thoughtful members who spearheaded the construction of the Kelly Memorial Building in the fifties, will understand why your officers may be scurrying about with designs for a new facility.

Philip H Cogan

Philip Cogan,
PRESIDENT

David Stewart First Professor of Pharmacy in America

by Ben Allen, Ph.D.

The Maryland College of Pharmacy was organized as a membership institution in the city of Baltimore. The initiatory conference in forming the College was held in the residence of Dr. Samuel G. Baker on June 8, 1840. The group attending included three prominent physicians (Baker was one) representing the Medical and Chirurgical Faculty of Maryland and eight apothecaries (David Stewart was one). After a lengthy discussion, the meeting finally decided to appoint a committee of five apothecaries (David Stewart, Secretary) to devise a plan for the formation of a College of Pharmacy.

On Monday evening, June 22, 1840, a meeting was held at Dr. Baker's residence and the Committee reported in favor of the formation of a College of Pharmacy in the City of Baltimore. At a general meeting of all regularly-educated apothecaries of the City held on July 6, 1840, Stewart made some appropriate remarks regarding the propriety and usefulness of such an institution. Also, at this meeting a Committee was appointed to draft a Constitution and By-laws for the College of Pharmacy (David Stewart was a member of this Committee).

A Constitution and By-laws were adopted at a meeting held on the evening of July 30, 1840, and the Maryland College of Pharmacy was finally ushered into existence. The meeting then proceeded to elect the first officers of the College (David Stewart elected to the three member Board of Examiners).

The act of incorporation for the College was passed by the Maryland Legislature during the December 1840 session and David Stewart's name appears as one of the incorporators.[1]

The incorporators, seventeen in number, immediately organized and established a course of instruction in Chemistry, Pharmacy and Materia Medica. It was decided that lectures, for a while at least, should be delivered by the various willing members of the College in regular rotation. Seven having thus consented (Stewart lectured on Chemistry), entered upon their duties the first week in November, 1841, for a period of six months. It was thus conducted until the close of the session 1843 and 1844, when it was considered best to have distinctive professors for each department.[2,3]

The first home of the new institution was a single back-room (little office) of Thomas G. Mackenzie's drugstore, north-east corner of Baltimore and Gay Streets, (where, even now, in passing I always give slight courtesy.)[4,5] The College functioned at this location during the period 1840–44.

On April 19, 1844, the Faculty of Physic of the University of Maryland offered to furnish a room in the University Building free of charge for use by the Maryland College of Pharmacy, and to advertise and include the Pharmacy College in the regular course so that their students may participate. All rights of the Maryland College of Pharmacy to be the same and there is to be no interference on the part of either College. The University offered the loan of apparatus for use at times when it can be spared. (This informal proposition was made by Professor Aikin.)[6] The Pharmacy College was requested to lecture on the second part of Wood and Bache's Dispensatory under the head of "Preparations" so that the Medical class may have the opportunity of attending lectures on practical Pharmacy. A committee of three (Stewart a member) was appointed to confer with Professor Aikin regarding the union of lectures in the two institutions.

In view of the problem of obtaining lecturers from the College membership (eight members delivered lectures at the previous session), a three member committee (Stewart was one) suggested that someone be appointed as Professor of Pharmacy. This was very important because of the proposed arrangement with the Medical University. The proposal was accepted, and the arrangement was consummated on April 24,

1844. On this date, Dr. David Stewart, an eminent Chemist and Pharmacist, who had taken the degree in Medicine at the University of Maryland at the recent commencement (March 1844)[7], was unanimously elected to Professor of Practical Pharmacy. On April 30th, the title was changed to the "Chair of Theory and Practice of Pharmacy" and Stewart was notified of this change. The Maryland College of Pharmacy thus has the honor of being the first institution in the country to establish an independent Chair of Pharmacy.[8,9,10] The lecturers of the Pharmacy College were delivered at the University of Maryland in Chemical Hall of "Old Main" (now Davidge Hall).

Prior to this time, in the College of Pharmacy, the subject of Pharmacy was taught by Medical Members (Physicians) of the Faculty in conjunction with the branch of Materia Medica or Chemistry. Also, a similar situation existed in Medical schools where the title often used was that of Professor of Materia Medica and Pharmacy or Chemistry and Pharmacy.[11,12]

William E. A. Aikin, Dean Faculty of Physic University of Maryland was very active in making the arrangement for the union of the two institutions.[13] He also turned over to the Maryland College of Pharmacy "room 20" in the old privately-owned and operated University at the northeast corner of Lombard and Greene Streets, for its meetings and cabinet of specimens. It is interesting to note that on two separate occasions Aikin was described as a Professor of Chemistry and Pharmacy (1837 and 1838).[14,15]

The Maryland College of Pharmacy was an Association of practitioners in the drug trade who were eager to conduct their activities on the basis of scientific knowledge and professional ideals, as well as commercial interests. David Stewart was extremely involved in the affairs of the College from its beginning (1840) and the records show payment of dues for a period of ten years and also some additional money payments to the College. He helped to complete the negotiations between the Pharmacy College and the Medical group of the University of Maryland for the delivery of Pharmacy lectures in Chemical Hall of the old Medical Building (now Davidge Hall).

David Stewart's interest in Pharmacy is illustrated by the following College activities.[16]

1841—Member of following Committees: Report on Pharmaceutical articles to be presented at meetings, prepare a list of prices to govern members of the College, analyze articles for the benefit of College members.

1842—Lecturer, Board Examiner for commencement, member of Committee "State of the funds of the College," arranged for public lecture and presentation of diplomas (first commencement, Thursday evening, June 9th at 8 o'clock), proposed improving some formulae in the new United States Pharmacopeia, member of Committee that drafted resolution on death of College member Thomas E. Brennan.

1843—re-elected member Board of Examiners, remarked on mercurial preparations and suggested a new formula (and procedure for compounding) for "mercury with chalk" (to improve the one in the United States Pharmacopeia), commented on blistering ointment and spanish flies, delivered an essay on cyanogen and its compounds and spoke against the use of cyanide of potassium as a remedial agent, stated that it was time (September) some arrangements were made for the lecurers for the ensuing winter and proposed a plan, however, a Committee of three was appointed (Stewart a member) to take the whole subject into consideration, he reported (October) for the Committee that the lectures during the Winter will be every Tuesday evening at 8 o'clock and each member of the College in order of his name shall lecture from the English Edition of Pereira's Materia Medica[a] for thirty minutes (or other authors upon subjects in order or give his own views on the subject) followed by a question and answer period.

1844—offered a resolution to increase the college membership fees, first time Stewart was referred to as Doctor (April 19th), elected second Vice-President of the College (January 30th), suggested the procurement of a suitable case for specimens and other apparatus (approved).

1845—Member of Committee appointed to investigate proposed new formulas by College members (and United States Pharmacopeia formulas), proposed (October 21st) a ten dollar fee for his course of lectures on Pharmacy which also entitled the student to attend Dr. Aikin's lectures on Chemistry, member of Committee to establish a Library, requested Board of Trustees to appropriate sufficient funds for the purchase of suitable books.

1846—Remarked on an essay delivered by a College member on narcotic extracts, Committee member to examine Pharmacopeia for revision at the National Convention in 1850, gave notice (March 31st) that he intended to resign as Professor, spoke on the preparation of ammonium phosphate, on motion of Mr. Mackenzie, the resignation of Dr. Stewart was asked for (April 28th) and Stewart resigned informally which was accepted, elected Secretary of the College (December 29th).

1847—Proposed a plan by which the college should appoint a standing committee for the examination of drugs and chemicals whose genuineness or purity was disputed (Stewart appointed member of this committee), appointed to new committee known as "Committee on Analysis," member of committee that reviewed a communication from the College of Pharmacy in New York (about this time, the New York City group was interested in a law requiring the observance of certain standards for imported drugs and chemicals[17]), reelected Secretary of the College, Committee (Stewart member) reported on the importation of spurious drugs.

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[a] Jonathan Pereira, M.D. of London, a distinguished Pharmacologist of his age. His death reported in the "Proceedings of the American Pharmaceutical Association", Boston (1853), p. 19.

David Stewart (1813–1899) was born in Port Penn, Delaware and educated at the New Castle Academy (Delaware). At about the age of eighteen, he was sent to Baltimore to study Pharmacy and Chemistry.[18] David Stewart and his brother James Van Dyke established in 1834 a drug store on the southeast corner of Hanover and Camden streets. At the time, it was the only store south of Baltimore Street in this section of the City.[19,20] David Stewart opened a second store on Charles Street north of Lexington Street (1839). Charles Street at this time being built up near the Washington Monument and many of Stewart's customers lived in this section (the customers previously patronized drugstores on Baltimore Street).

In 1841, a Baltimore City directory listed David Stewart, Druggist, Southeast corner Hanover and Camden Streets. He was also in 1842 the preceptor for Frederick A. Cochrane, one of the first three graduates from the Maryland College of Pharmacy.[21] (It is difficult to imagine that this area, Hanover and Camden streets, was a residential neighborhood with large town houses. Today, on the northwest corner of Pratt and Sharp streets still stands the house, somewhat modified for a commercial use, and purchased in 1821 by Moses Sheppard. Upon his death he left money for the establishment of a mental hospital, later known as Sheppard-Pratt. Mr. Sheppard occupied the house for thirty-six years and was visited by presidents of banks, railroads and other businesses. Today, the Stewart drug store site is occupied by the Baltimore Convention Center.[22])

Stewart and his brother dissolved the partnership and after selling his second store (about or after 1844) to College member Rufus T. Littlefield, he practiced medicine in the City for some years, but made no success of it.[23]

David Stewart was very active in civil affairs during the early years and his political career was no doubt advanced by his marriage (at the age of twenty-two) to a daughter of an Eastern Shore Judge. He served as a member of the Baltimore City Council (1835–37), School Commissioner of Baltimore (1836), Ruling Elder of the First Presbyterian Church (1838), and member of the State Senate (1840).[24]

In 1851, Pharmaceutists and druggists met in the city of New York to discuss ways of assuring the quality of imported drugs and the need for a national pharmaceutical association. At this convention (the first of the kind ever assembled in the United States) a letter from Dr. Stewart was read giving his views in regard to the subject of "Legal Standards for Drugs." (David Stewart was Inspector of Drugs, Port of Baltimore, 1850–53.)[25,26]

Dr. Stewart continued his interest in Pharmacy for many years after receiving his medical degree. He was one of two delegates from the Maryland College of Pharmacy[b] at the National Pharmaceutical Convention (1852) held in Philadelphia. He was very active at this meeting and participated in a debate on "Good Drugs, etc." Also, Stewart was appointed to the Business Committee, as well as, the Committee on the Inspection of Drugs. At this time, he was the first to officially use the title "The American Pharmaceutical Association." (He made a motion that this title be used in Boson the following year.)[27]

At the Boston meeting of the American Pharmaceutical Association in 1853, the name of David Stewart appears on a Committee to prepare an address to the Pharmaceutists of the United States on the subject of "Pharmaceutical Education." However, he was not in attendance at the meeting.[28]

The report of the Committee on Education (Stewart a member) was read and accepted at the Cincinnati meeting in 1854. Also, at this meeting, Dr. David Stewart was selected to serve on a special committee to judge essays.[29] He was re-appointed the following year to the Committee of Judges.[30] This Committee reported[31] at the Annual Meeting held in the City of Baltimore (1856) in the Hall of the College of Dental Surgery[c] and Stewart's name was missing from the report. (Osborne states that Stewart never attended a meeting after his brilliant participation in the founding of the American Pharmaceutical Association.[32])

Never one to be satisfied with a routine of narrow interests, Dr. David Stewart busied himself in the Fall of 1847 with three other Medical practitioners in founding the Maryland Medical Institute, a preparatory school of medicine established at the corner of Fayette Street and Elbow Alley.[33,34] He also was interested in the Medical and Chirurgical Faculty of Maryland, and presented the following reports:[35] Chemistry and Pharmacy (1847), Materia Medica and Pharmacy (1849), on the Pharmacopeia (1853 and 1855).[36] His other "Faculty" activities included a committee to expel guilty members for violation of rules regarding advertising, endorsing various medications, treatments, etc. (1848), member of the Library Board (1849), reported on the systems of weights and measures being used and urged the adoption, etc. of the Metric System (1855).

It is interesting to note that in 1853 the Baltimore Pathological Society was founded by Dr. Stewart and eight other Doctors.[37]

In the July number, 1853, of the New York Journal of Pharmacy, a formula was published of Dr. David Stewart, for a preparation of Opium, intended as a substitute for Laudanum, and also as a substitute for the nostrum known as McMunn's Exlixir of Opium. (Stewart's formula contained opium, lime, water, ammonium chloride, and alcohol.)[38]

Dr. David Stewart accepted the professorship of Chemistry and Natural Philosophy on the Faculty of St. John's College in Annapolis (1855–62) and at the same time was acting as Chemist to the State Agricultural Society. Also, at one time he was acting President of the College.[39]

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[b] Note: College inactive at this time.

[c] The approximate location of this institution was on Sharp Street near Baltimore; later this site was occupied by the Hopkins Place Savings Bank (No. 7 Hopkins Place) across the street from the Civic Center near the present Federal Building in Hopkins Plaza.

At the annual session of the Medical and Chirurgical Faculty of Maryland, held June 1, 1856, the following motion, offered by Dr. F. E. B. Hintze, was adopted: "That this Faculty highly approve of the reorganization of the Maryland College of Pharmacy, and bespeak for its judicious code of ethics the cordial support of the legitimate members of the Medical profession."[40] In 1858, the Pharmacy College rented from the Medical and Chirurgical Faculty apartments on the second floor of its new building at 47 North Calvert Street, second door south of Saratoga[41] (this new "Hall," first possession by the "Faculty" of its own building). In addition to the advantages of comfortable meeting and lecture rooms, the Pharmacy College here became a neighbor of several Medical societies.[43]

The College of Pharmacy continued to occupy the Hall of the Medical and Chirurgical Faculty until the close of 1867, when the sale by the "Faculty" of its Calvert Street property necessitated a removal to a building at No. 12 West Baltimore Street, a few doors west of the bridge (over Jones Falls), on the north side.[44]

The minutes of the Maryland College of Pharmacy of February 5, 1857 records the purchase of chemical apparatus by Professor Stewart for use by the Pharmacy College and that he was to be repaid for this purchase. About this time, Stewart was invited by the College to the commencement on March 6th to be held in Masonic Hall (Corner of St. Paul Street and Court House Lane).[45] In 1858, the Maryland College of Pharmacy listed Professor David Stewart as an honorary member of the College. At this time, Professor William Procter, Jr. of Philadelphia, the so-called "Father of American Pharmacy" was also listed as Honorary Member.[46]

David Stewart returned to Port Penn, Delaware in 1862 and lived the life of a gentleman.[47] On January 12, 1871, the Maryland College of Pharmacy conferred the Doctor of Pharmacy degree on David Stewart and William Procter, Jr.[48]

Dr. Stewart died at Port Penn on September 2, 1899, age 86.[49]

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32. Reference 18, p. 225.
33. Reference 26.
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35. Reference 10, pp. 115, 121, 125, 134.
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calendar

Feb. 14 (Sunday)—BMPA Dinner Dance, Blue Crest

Mar. 8-11—NARD Legislative Conference, Washington

Mar. 14 (Sunday)—Alumni Association Dinner Meeting—Johnie Walker, Speaker

April 24-29—APhA Convention, Las Vegas

June 18-20—Maryland Society Hospital Pharmacist Seminar, Williamsburg

June 20-24—MPhA Centennial Convention, Ocean City

Industry Relations Committee

OTC Reformulations

The Question

Dear Sir,

The Maryland Pharmaceutical Association is the statewide professional society of Pharmacists. The Industry Relations Committee of the Association is the body charged with ombudsman responsibility in the interactions between pharmacists and manufacturing interests. It is made up of both pharmacists and manufacturing representatives.

Recently the Committee examined the increasing number of OTC products that are being reformulated and is seeking information from specific companies on this matter. We are aware of the Proprietary Association's guidelines regarding the "flagging" of reformulated products. However, the Committee would appreciate your specific response to the following questions:

1. What OTC products from your company have undergone reformulation in the past four years?
2. What were the ingredient changes for each of these products? (old-new)
3. What were the reasons that these products were reformulated?
4. Do you anticipate that any of your products will be reformulated in the future? If so, please list them with expected changes and date of change.
5. What is your company's general policy with regard to "flagging" reformulated products for the information of the pharmacist and consumer?

It is the Committee's intention to compile and analyze this information, and eventually publish it for the information of Maryland Pharmacists. We sincerely appreciate your assistance with this important Committee project. Please advise me whenever the Association or the Industry Relations Committee may be of some assistance.

Sincerely,
David A. Banta
Executive Director

The Answers

Dear Mr. Banta:

This is in response to the questions pertaining to our OTC products in your letter of May 1, 1981. The following response pertains to Schering labeled OTC products.

Q.1. What OTC products from your company have undergone reformulation in the past four years?

—None

Q.4. Do you anticipate that any of your products will be reformulated in the future? If so, please list them with expected changes and date of change.

	OLD	NEW
DEMAZIN Repetabs Tablets		
Chlorpheniramine Maleate (CTM)	4.0 mg.	4.0 mg.
Phenylpropanolamine Hcl (PPA)	0	25.0 mg.
Phenylephrine Hcl (PE)	20.0 mg.	0
DEMAZIN Syrup (per 5 ml.)		
CTM	1.0 mg.	2.0 mg.
PPA	0	12.5 mg.
PE	2.5 mg.	0

The changes are planned to reformulate according to proposed Federal guidelines, and will take place later in 1981 once approved by the U.S. FDA (application is under FDA review).

Q.5. What is your company's general policy with regard to "flagging" reformulated products for the information of the pharmacist and consumer?

— Company policy requires that reformulation of active ingredients in Rx and OTC products be "flagged" for the benefit of MD, Pharmacist, and consumer customers.

With regard to the EMKO® line of products, please direct your inquiry to:

Mr. Charles Salivar
Director of Operations
EMKO Products
c/o Schering Corporation
411 E. Gano Avenue
St. Louis, Mo. 63147

Yours truly,
Harold J. Fazio
Manager, Research &
Regulatory Liaison
Schering Corp.

Dear Mr. Banta:

In your letter of May 4, 1981 you inquired as to the nature and extent of Warner-Lambert Company's reformulation of OTC products over the past four years.

Let me begin by noting that this letter will address only those OTC drub products marketed by the Consumer Products Group of the Warner-Lambert Company. A copy of your letter has been forwarded to our

Parke-Davis Division in connection with those OTC drug products which they market.

As an additional point of clarification, we assume that by reformulation you are specifically addressing the reformulation of active ingredients. To that issue, no Warner-Lambert Consumer Products Group OTC drug product has undergone active ingredient reformulation in the past four years.

As you correctly noted, the Proprietary Association does have guidelines regarding the "flagging" of reformulated products. Warner-Lambert Company, as an active member of that association, of course, adheres to those guidelines.

In terms of anticipated product changes, we regret that our future plans must be regarded as confidential in nature. You can, however, be assured that we maintain a constant vigilance over our formulations, a vigilance mandated by forever changing scientific, regulatory and marketing requirements.

Thank you for your interest. If we can be of further assistance, please feel free to let us know.

Sincerely,
John Purkert
Regulatory Affairs
Consumer Products Group
Warner Lambert

Dear Sir:

Your letter of inquiry regarding changes in Bristol-Myers Products formulas has been forwarded to my office for response.

Our policy has always been that our products' formulas, reasons for changes therein, and plans for, or possibly future changes are confidential information which we cannot release. We do provide current formula information to regulatory and other governmental agencies, and to compendial sources.

Bristol-Myers is a member of the Proprietary Association and subscribes to the P. A. "flagging" guidelines (May, 1977) published by that group. Examples of products which have been "flagged" for up to six months after formula changes are EXCEDRIN, EXCEDRIN PM and 4-WAY Cold Tablets.

Some of the kinds of information you desire will be found by referencing several years of the annual *Physicians Desk Reference for Nonprescription Drugs*. Therein are listed many Bristol-Myers and other OTC manufacturers' products and their formulas.

Thank you very much for your interest in Bristol-Myers.

Sincerely,
Ruth M. Palmes, M.D.
Bristol-Myers

Dear Mr. Banta:

In response to your recent letter we are pleased to provide the following information about our product line.

Over the years, there have been several Plough products which have been reformulated, however, most of these have involved changes in inactive ingredients or minor adjustments of levels of active ingredients.

Formulation changes are made for a variety of reasons, including availability of new ingredients which improve the characteristics of the product, currently used ingredients which may no longer be available, replacement of ingredients with actual or alleged concerns of safety, or general reformulation to improve product performance.

As with most OTC product manufacturers, we anticipate reformulation may be required of several of our products as a result of FDA's on-going review of all OTC products. However, specifics will not be known until these monographs are finalized.

As an active member of the Proprietary Association, we follow their "flag the label" guidelines as described in the attachment.

Thank you for this opportunity to provide information to your association.

Sincerely,
Kenneth R. Johannes
Director Regulatory Affairs
Plough, Inc.

Dear Mr. Banta:

I am in receipt of your letter dated 1 May 1981 requesting information on reformulated OTC products.

During the past four years we have had few changes in our proprietary products. The following products have, however, had minor modifications:

Chloraseptic® (original menthol-green) yellow #5 (tartrazine) has been deleted from the liquid product.

NP-27 products formerly contained orthochloromercuriphenol or 8-hydroxy quinoline benzoate. All products now contain either undecylic acid or zinc undecylinate. These changes were made to provide consistent formulation for the product line. In addition the fluorocarbons have been deleted from NP-27 aerosol powder. A new aerosol system containing hydrocarbons has been substituted.

Unguentine® fluorocarbons have been deleted from the aerosol product. Hydrocarbons have been substituted as a propellant.

We do not anticipate any reformulation for other OTC products at this time.

Our Company's general policy in regard to "flagging" reformulated products is in agreement with the PA policy on such information.

If I can be of any further assistance to you, please feel free to contact me.

Sincerely,
Dennis B. Worthen, Ph.D.
Chief, Information Services
Norwich-Easton
Pharmaceuticals

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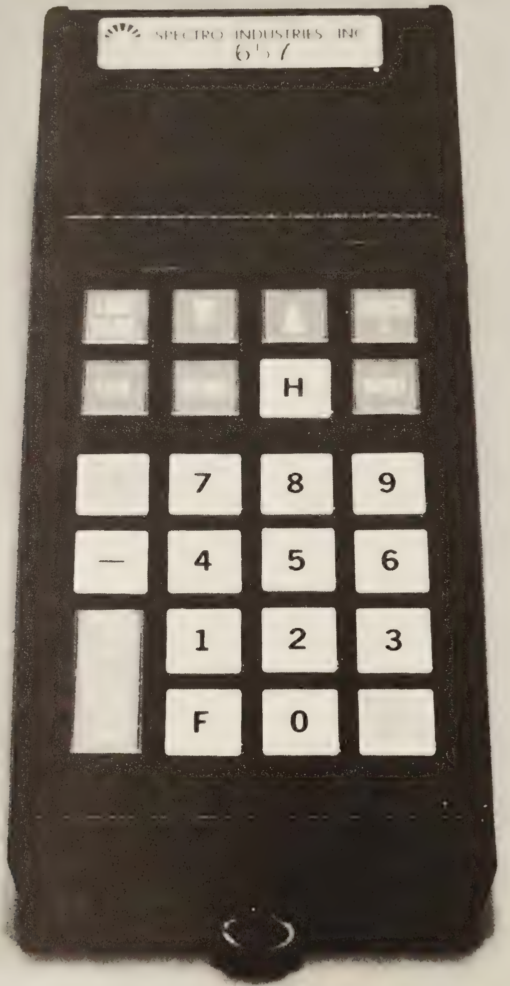

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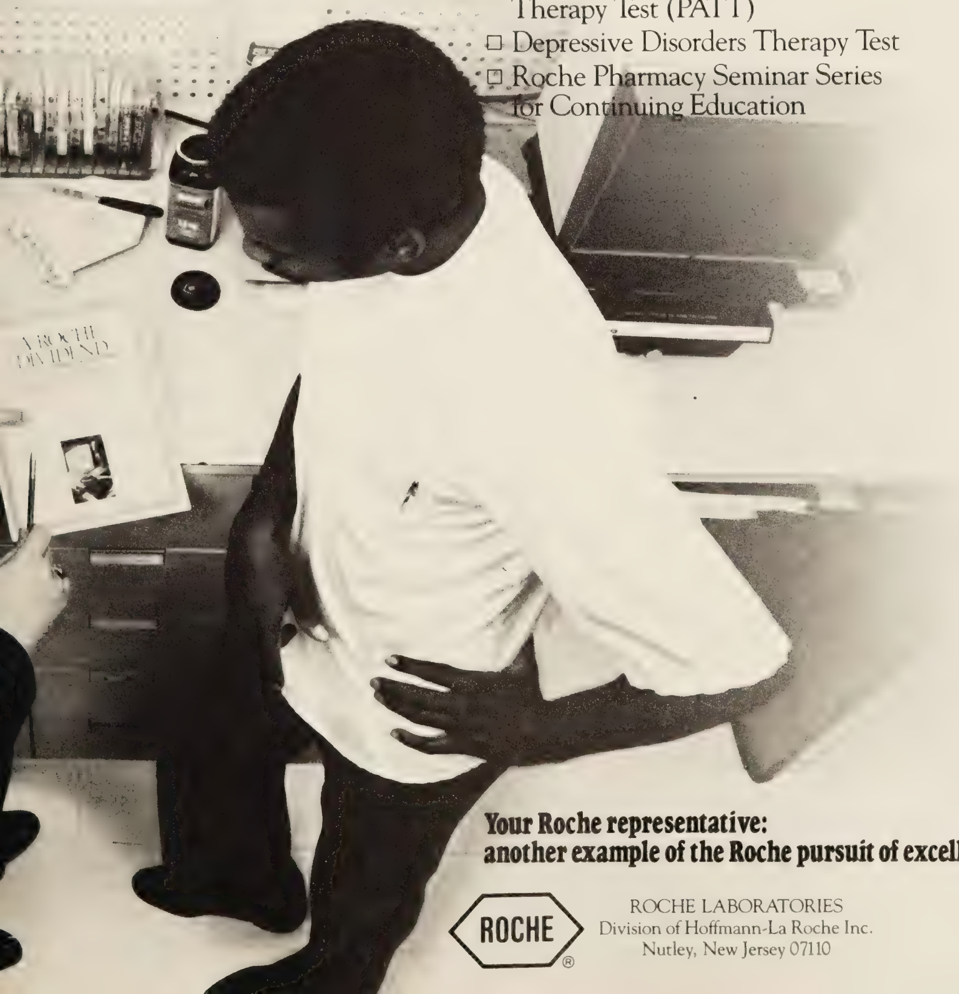

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Manufacturer disclosure

To keep drug product selection a workable concept, pharmacists need information about the source of drug products before they purchase them.

The California Pharmacists Association wrote to drug manufacturers and distributors, asking them to provide new and updated information on which companies actually manufacture the final dosage form. On these pages is the latest information provided to the association.

We have added some drugs to the list because they are now available from a greater number of sources. All information concerning the manufacturers of drug products applies only to those dosage forms and strengths distributed by the companies. The distributor appears on the left, the manufacturer on the right.

Acetaminophen with Codeine ¼, ½ and 1 gr tabs

Barr Labs	Barr Labs
Burroughs Wellcome Co.	Burroughs Wellcome Co.
H.R. Cenci Labs	Cord Labs
Drummer Labs	Lemmon
Geneva Generics	Cord Labs
Ladco Labs	Rugby Labs[1]
Lederle Labs	KV Pharm. or Barr Labs
Lemmon	Lemmon
McKesson Labs*	Danbury Pharmacal
McNeil Pharm.	McNeil Pharm.
Parke-Davis	Parke-Davis
Parmed Pharm.	Cord Labs
Penta Products	Halsey Drug Co. or Zenith Labs
Philips Roxane	Philips Roxane
Purepac	Halsey Drug Co.
Rugby Labs	Halsey Drug Co.
Smith Kline & French	Philips Roxane
Stayner Corp.	Philips Roxane
Towne, Paulsen & Co.	Towne, Paulsen & Co.
Vangard Labs*	Heun/Norwood Labs
West-Ward*	Halsey Drug Co.
Wolins Pharmacal*	Blue Cross Products or Zenith Labs

Allopurinol 100 mg, 300 mg

Boots Pharm.	Generic Pharm.
Burroughs Wellcome Co.	Burroughs Wellcome Co.

Aminophylline 100 and 200 mg tabs

H.R. Cenci Labs	Richlyn Labs or Cord Labs
Coast Labs	Cord Labs
Geneva Generics	Cord Labs
ICN Pharm.*	ICN Pharm.
Invenex Pharm.*	Invenex Pharm.
McKesson Labs*	Richlyn Labs
Ladco Labs	Rugby Labs[1] or Chelsea Labs
Parmed Pharm.	Ormont Drug
Penta Products	Halsey Drug or Richlyn Labs
Purepac	Cord Labs
Rugby Labs	Chelsea Labs
Searle Pharm.	Searle & Co.
Stayner Corp.	Cord Labs
Vangard Labs*	Richlyn Labs
West-Ward*	West-Ward
Wolins Pharmacal*	Richlyn Labs or Blue Cross Products

Amitriptyline HCl 10, 25 and 50 mg tabs

Barr Labs	Barr Labs
H.R. Cenci Labs	M.D. Pharm.
Coast Labs	M.D. Pharm.
Geneva Generics	Cord Labs
Hoffmann-La Roche	Hoffmann-La Roche
Ladco Labs	Rugby Labs[1] or Chelsea Labs
Lederle Labs	Biocraft Labs
McKesson Labs*	Barr Labs
Parke-Davis	Parke-Davis
Parmed Pharm.	Biocraft Labs or Cord Labs
Penta Products	Barr Labs
Philips Roxane	Philips Roxane
Purepac	Biocraft Labs or Cord Labs
Rexall Drug Co.	Barr Labs
Rugby Labs	Chelsea Labs
Smith Kline & French	Philips Roxane
Stayner Corp.	Barr Labs
E.R. Squibb & Sons	E.R. Squibb & Sons
Vangard Labs*	Biocraft Labs
West-Ward*	Cord Labs
Wolins Pharmacal*	Biocraft Labs

Amoxicillin 125 mg liquid and caps and 500 mg caps

Beecham Labs	Beecham Labs
Geneva Generics	Biocraft Labs
Hoffman-La Roche	Hoffmann-La Roche
Ladco Labs	Rugby Labs[1] or Biocraft Labs
Parke-Davis	John D. Copanos & Co.
Parmed Pharm.	Biocraft Labs or Mylan Pharm.
Penta Products	Biocraft Labs
Rexall Drug Co.	Biocraft Labs
A.H. Robins Co.	Biocraft Labs
Rugby Labs	Biocraft Labs
E.R. Squibb & Sons	E.R. Squibb & Sons
Vangard Labs*	Biocraft Labs
Wolins Pharmacal*	Biocraft Labs
Wyeth Labs	Wyeth Labs

Ampicillin 125 and 250 mg liquid and 125, 250 and 500 mg caps

H.R. Cenci Labs	Biocraft Labs
Coast Labs	Mylan Pharm.
Geneva Generics	Mylan Pharm., Biocraft Labs or Zenith Labs
ICN Pharm.*	Mylan Pharm.
Ladco Labs	Rugby Labs[1] or Biocraft Labs
Lederle Labs	Mylan Pharm.
McKesson Labs*	Mylan Pharm.
Parke-Davis	John D. Copanos & Co.
Parmed Pharm.	Biocraft Labs or Mylan Pharm.
Penta Products	Biocraft Labs
Pfipharmecs	Pfizer
Purepac	Purepac
Rexall Drug Co.	Biocraft Labs
Rugby Labs	Mylan Pharm. or Biocraft Labs
Smith Kline & French	Bristol Labs
E.R. Squibb & Sons	E.R. Squibb & Sons

** No response was received from this company. The information listed has been taken from previous articles.*

[1] *See the Rugby listing to determine the manufacturer of this product.*

- Towne, Paulsen & Co. — International Labs, John D. Copanos & Co. or Biocraft Labs
- Vangard Labs* — Biocraft Labs
- West-Ward* — Zenith Labs
- Wolins Pharmacal* — Biocraft Labs, Chromalloy Pharm., Mylan Pharm. or Zenith Labs
- Wyeth Labs — Wyeth Labs

APC with Codeine ⅛, ¼, ½ and 1 gr tabs

- Burroughs Wellcome Co. — Burroughs Wellcome Co.
- H.R. Cenci Labs — Zenith Labs
- Geneva Generics — Cord Labs
- ICN Pharm.* — ICN Pharm.
- Lederle Labs — Barr Labs
- Eli Lilly & Co. — Eli Lilly & Co.
- McKesson Labs* — Danbury Pharmacal
- Parke-Davis — Parke-Davis
- Parmed Pharm. — Zenith Labs or Danbury Pharmacal
- Penta Products — Halsey Drug Co. or Zenith Labs
- Rugby Labs — Halsey Drug Co.
- Stayner Corp. — Cord Labs
- Towne, Paulsen & Co. — Towne, Paulsen & Co.
- Vangard Labs* — Graham
- West-Ward* — Halsey Drug Co.
- Wolins Pharmacal* — Blue Cross Products or Zenith Labs
- Wyeth Labs — Wyeth Labs

Aspirin with Codeine ⅛, ¼, ½ and 1 gr

- Burroughs Wellcome Co. — Burroughs Wellcome Co.
- Geneva Generics — Cord Labs
- Ladco Labs — Rugby Labs[1]
- Parke-Davis — Parke-Davis
- Parmed Pharm. — Cord Labs or Halsey Drug Co.
- Penta Products — Zenith Labs
- Rugby Labs — Halsey Drug Co.
- Stayner Corp. — Cord Labs

Belladonna Alkaloids with Phenobarbital tabs

- Beecham Labs — Beecham Labs
- H.R. Cenci Labs — Richlyn Labs or Drummer Labs
- Coast Labs — Cord Labs
- Drummer Labs — Lemmon
- Geneva Generics — Cord Labs
- Invenex Pharm.* — Invenex Pharm. or Cord Labs
- Lemmon — Lemmon
- Parmed Pharm. — Zenith Labs or Rondex Labs
- Penta Products — Halsey Drug Co.
- Purepac — Purepac
- A.H. Robins — A.H. Robins
- Rugby Labs — Drummer Labs
- Stayner Corp. — Rondex Labs
- Towne, Paulsen & Co. — Towne, Paulsen & Co.
- Vangard Labs — Drummer Labs
- West-Ward* — West-Ward

Brompheniramine Maleate with Decongestant elixir and expectorant

- H.R. Cenci Labs — H.R. Cenci Labs
- Lederle Labs — National Pharm.
- Life Labs — Life Labs
- Penta Products — Life Labs
- A.H. Robins — A.H. Robins
- Rugby Labs — Bay Labs or National Pharm.
- Stayner Corp. — Bay Labs

Butabarbital 15, 30 and 50 mg tabs

- Coast Labs — Cord Labs
- Drummer Labs — Lemmon
- Geneva Generics — Cord Labs
- Invenex Pharm.* — Invenex Pharm.
- McNeil Pharm. — McNeil Pharm.
- Parmed Pharm. — Zenith Labs or Cord Labs
- Penta Products — Halsey Drug Co.
- Rugby Labs — Marshall Pharm. or Chelsea Labs
- Towne, Paulsen & Co. — Towne, Paulsen & Co.
- Vangard Labs* — Zenith Labs
- West-Ward* — West-Ward
- Wolins Pharmacal* — Drummer Labs

Chloral Hydrate 500 mg caps

- H.R. Cenci Labs — R.P. Scherer Corp.
- Coast Labs — R.P. Scherer Corp.
- Geneva Generics — R.P. Scherer Corp.
- ICN Pharm.* — R.P. Scherer Corp.
- Invenex Pharm.* — R.P. Scherer Corp.
- Ladco Labs — Rugby Labs[1] or R.P. Scherer Corp.
- Lederle Labs — R.P. Scherer Corp.
- McKesson Labs* — R.P. Scherer Corp.
- Parke-Davis — R.P. Scherer Corp.
- Penta Products — Chase Chemicals or Banner
- Philips Roxane — R.P. Scherer Corp.
- Purepac — R.P. Scherer Corp.
- Rugby Labs — R.P. Scherer Corp. or Encapsulations
- Smith Kline & French — R.P. Scherer Corp.
- E.R. Squibb & Sons — R.P. Scherer Corp.
- Stayner Corp. — R.P. Scherer Corp.
- Towne, Paulsen & Co. — R.P. Scherer Corp.
- Vangard Labs* — R.P. Scherer Corp.
- West-Ward* — R.P. Scherer Corp.
- Wolins Pharmacal* — Banner, Gelaton, R.P. Scherer Corp. or Encapsulations
- Wyeth Labs — R.P. Scherer Corp.

Chlordiazepoxide HCl 5, 10 and 25 mg caps

- Abbott Labs — Abbott Labs
- Barr Labs — Barr Labs
- H.R. Cenci Labs — Western Research Labs
- Geneva Generics — Cord Labs
- Hoffmann-La Roche — Roche Products
- Lederle Labs — Barr Labs or Western Research Labs
- McKesson Labs* — McKesson Labs
- Parke-Davis — Parke-Davis
- Parmed Pharm. — Cord Labs, Richlyn Labs or Premo Pharm.
- Penta Products — Barr Labs
- Philips Roxane — Philips Roxane
- Purepac — Purepac
- Rachelle Labs — Rachelle Labs
- Rexall Drug Co. — Mylan Pharm.
- Rugby Labs — Chelsea Labs
- Smith Kline & French — Smith Kline & French
- E.R. Squibb & Sons — Mylan Pharm.
- Stayner Corp. — Barr Labs
- Towne, Paulsen & Co. — Western Research Labs
- Vangard Labs* — Western Research Labs
- West-Ward* — West-Ward
- Wolins Pharmacal* — Cord Labs, Zenith Labs Barr Labs or Mylan Pharm.

Chlorothiazide 250 and 500 mg tabs

- H.R. Cenci Labs — Bolar Pharm.
- Coast Labs — Mylan Pharm.
- Geneva Generics — Bolar Pharm. (250 mg) Mylan Pharm. (500 mg)
- Ladco Labs — Rugby Labs[1], Mylan Pharm. or Bolar Pharm.
- Lederle Labs — Mylan Pharm.

** No response was received from this company. The information listed has been taken from previous articles.*

[1] See the Rugby listing to determine the manufacturer of this product.

McKesson Labs	Mylan Pharm.
Merck Sharp & Dohme	Merck Sharp & Dohme
Parmed Pharm.	Bolar Pharm. or Mylan Pharm.
Purepac	Mylan Pharm.
Rugby Labs	Mylan Pharm.
Smith Kline & French	Mylan Pharm.
E.R. Squibb & Sons	Mylan Pharm.
Stayner Corp.	Mylan Pharm.
Towne, Paulsen & Co.	Mylan Pharm.
Vangard Labs*	Mylan Pharm.
West-Ward*	Danbury Pharmacal (250 mg) Mylan Pharm. (500 mg)
Wolins Pharmacal*	Mylan Pharm.

Chlorpheniramine Maleate 4 mg tabs

Barr Labs	Barr Labs
H.R. Cenci Labs	Cord Labs
Coast Labs	Cord Labs
Drummer Labs	Lemmon
Geneva Generics	Cord Labs
ICN Pharm.*	ICN Pharm.
Invenex Pharm.*	Invenex Pharm.
Ladco Labs	Rugby Labs[1]
Lederle Labs	Generic Pharm.
McKesson Labs*	Danbury Pharmacal
Parmed Pharm.	Zenith Labs or Danbury Pharmacal
Penta Products	Barr Labs
Philips Roxane	Philips Roxane
Purepac	Purepac
Rugby Labs	Chelsea Labs
Schering Corp.	Schering Corp.
Stayner Corp.	Cord Labs
Towne, Paulsen & Co.	Towne, Paulsen & Co.
Vangard Labs*	Generic Pharm.
West-Ward*	West-Ward
Wolins Pharmacal*	Tablicaps or Generic Pharm.

Chlorpheniramine Maleate with Phenylephrine liquid

H.R. Cenci Labs	H.R. Cenci Labs
Merrell Dow Pharm.	Merrell Dow Pharm.
Rugby Labs	National Pharm.
Schering Corp.	Schering Corp.

Chlorpromazine HCl 25 and 50 mg tabs

H.R. Cenci Labs	Western Research Labs
Geneva Generics	Cord Labs
Ladco Labs	Rugby Labs[1], Cord Labs or Zenith Labs
Lederle Labs	Western Research Labs
McKesson Labs*	Zenith Labs
Parke-Davis	Cord Labs
Parmed Pharm.	Zenith Labs or Cord Labs
Penta Products	Western Research Labs or Zenith Labs
Philips Roxane	Cord Labs
Purepac	Cord Labs
Rugby Labs	Cord Labs, Zenith Labs or Chelsea Labs
Stayner Corp.	Cord Labs
Towne, Paulsen & Co.	Western Research Labs or Cord Labs
Vangard Labs*	Western Research Labs

West-Ward*	Zenith Labs
Wolins Pharmacal*	Western Research Labs

Chlorpropamide[2] 100 and 250 mg tabs

Ladco Labs	Rugby Labs
Parmed Pharm.	Premo Pharm.
Pfizer Labs	Pfizer Pharm.
Rugby Labs	Pharmadyne

Chlorthalidone 25, 50 and 100 mg tabs

Abbott Labs	Abbott Labs
Barr Labs	Barr Labs
H.R. Cenci Labs	Bolar Pharm.
Geneva Generics	Cord Labs or Mylan Pharm.
Ladco Labs	Premo Pharm.
Lederle Labs	Mylan Pharm. or Lederle Labs
Parmed Pharm.	Bolar Pharm. or Premo Pharm.
Penta Products	Zenith Labs or Barr Labs
Rugby Labs	Bolar Pharm. or Mylan Pharm.
Towne, Paulsen & Co.	Bolar Pharm.
USV Labs	USV Labs

Colchicine 0.6 mg tabs

Abbott Labs	Abbott Labs
Barr Labs	Barr Labs
H.R. Cenci Labs	Zenith Labs
Geneva Generics	Zenith Labs
Eli Lilly & Co.	Eli Lilly & Co.
Ladco Labs	Rugby Labs[1] or Chelsea Labs
McKesson Labs*	Danbury Pharmacal
Parmed Pharm.	Danbury Pharmacal or Zenith Labs
Penta Products	Barr Labs
Purepac	Purepac
Rugby Labs	Chelsea Labs
Towne, Paulsen & Co.	Generic Pharm.
Vangard Labs*	Zenith Labs
West-Ward*	West-Ward
Wolins Pharmacal*	Danbury Pharmacal, Generic Pharm. or Zenith Labs

Conjugated Estrogens 0.625, 1.25 and 2.5 mg tabs

Ayerst Labs	Ayerst Labs
H.R. Cenci Labs	Cord Labs or Zenith Labs
Coast Labs	Cord Labs
Geneva Generics	Cord Labs
Ladco Labs	ICN Pharm.
McKesson Labs*	Cord Labs
Parmed Pharm.	Cord Labs, Heather Drug Co. or ICN Pharm.
Penta Products	Zenith Labs
Purepac	Cord Labs or ICN Pharm.
Rugby Labs	Cord Labs or Chelsea Labs
Stayner Corp.	ICN Pharm.
Vangard Labs*	ICN Pharm.
West-Ward*	Cord Labs
Wolins Pharmacal*	ICN Pharm. or Heather Drug Co.

Dexamethasone 0.75 mg tabs

Barr Labs	Barr Labs
Coast Labs	Cord Labs
Geneva Generics	Cord Labs
McKesson Labs*	Cord Labs
Merck Sharp & Dohme	Merck Sharp & Dohme
Parmed Pharm.	Danbury Pharmacal or Cord Labs
Penta Products	Barr Labs
Philips Roxane	Philips Roxane
Purepac	Cord Labs
Rowell Labs	Rowell Labs
Rugby Labs	Chelsea Labs

** No response was received from this company. The information listed has been taken from previous articles.*

[1] See the Rugby listing to determine the manufacturer of this product.

[2] Pfizer reports that it holds the patent on this product and says, "No other company has been licensed by Pfizer to manufacture, sell or distribute these products." Since other companies also reported manufacturing or distributing this product we are listing this information but make no representation as to the legitimacy of any seller's claims.

Smith Kline & French – – – – Philips Roxane
Stayner Corp. – – – – – – – Cord Labs
Towne, Paulsen & Co. – – – – Towne, Paulsen & Co.
Vangard Labs* – – – – – – – ICN Pharm.
West-Ward* – – – – – – – – Cord Labs
Wolins Pharmacal – – – – – – ICN Pharm.
or Heather Drug Co.

Dicloxacillin 250 and 500 mg caps
Beecham Labs – – – – – – – Beecham Labs
Wyeth Labs – – – – – – – – Wyeth Labs

Dicyclomine 10 and 20 mg tabs or caps
Barr Labs – – – – – – – – – Barr Labs
H.R. Cenci Labs – – – – – – Bolar Pharm.
Coast Labs – – – – – – – – Bolar Pharm.
Drummer Labs – – – – – – – Lemmon
Geneva Generics – – – – – – Barr Labs
Lederle Labs – – – – – – – – Barr Labs
or Danbury Pharmacal
McKesson Labs* – – – – – – Danbury Pharmacal
Merrell Dow Pharm. – – – – – Merrell Dow Pharm.
Parmed Pharm. – – – – – – – Bolar Pharm.
or Danbury Pharmacal
Penta Products – – – – – – – Barr Labs
Rugby Labs – – – – – – – – Chelsea Labs
Stayner Corp. – – – – – – – Generic Pharm.
Towne, Paulsen & Co. – – – – Generic Pharm.
or Barr Labs
Vangard Labs* – – – – – – – Generic Pharm.
Wolins Pharmacal* – – – – – Tablicaps, Richlyn Labs
or Generic Pharm.

Diethylpropion HCl 25 mg, 75 mg tabs
Coast Labs – – – – – – – – M.D. Pharm.
Drummer Labs – – – – – – – Lemmon
Geneva Generics – – – – – – M.D. Pharm. (25 mg)
Riker Pharm. (75 mg)
Merrell Dow Pharm. – – – – – Merrell Dow Pharm.
Parmed Pharm. – – – – – – – M.D. Pharm.
Purepac – – – – – – – – – – M.D. Pharm.
Riker Labs – – – – – – – – – Riker Labs
Rugby Labs – – – – – – – – M.D. Pharm.
or Chelsea Labs
Towne, Paulsen & Co. – – – – M.D. Pharm.

Diethylstilbestrol tabs
Eli Lilly & Co. – – – – – – – – Eli Lilly & Co.
Miles Pharm. – – – – – – – – Miles Pharm.
Penta Products – – – – – – – Tablicaps
Rugby Labs – – – – – – – – Tablicaps

Digitoxin 0.1 and 0.2 mg tabs
Barr Labs – – – – – – – – – Barr Labs
Invenex Pharm.* – – – – – – – Invenex Pharm.
Eli Lilly & Co. – – – – – – – – Eli Lilly & Co.
McKesson Labs* – – – – – – Barr Labs
Parmed Pharm. – – – – – – – Zenith Labs
Purepac – – – – – – – – – – Purepac
Rugby Labs – – – – – – – – Barr Labs or Purepac
Towne, Paulsen & Co. – – – – Towne, Paulsen & Co.
Vangard Labs* – – – – – – – Ketchum Labs
West-Ward* – – – – – – – – West-Ward
Wolins Pharmacal* – – – – – Zenith Labs, Barr Labs
or Ketchum Labs

Digoxin 0.25 mg tabs
Burroughs Wellcome Co. – – Burroughs Wellcome Co.
Geneva Generics – – – – – – Zenith Labs
McKesson Labs* – – – – – – Zenith Labs
Parmed Pharm. – – – – – – – Zenith Labs
Penta Products – – – – – – – Zenith Labs
Purepac – – – – – – – – – – Purepac
Rugby Labs – – – – – – – – Halsey Drug Co.
Smith Kline & French – – – – Philips Roxane
Towne, Paulsen & Co. – – – – Towne, Paulsen & Co.
Vangard Labs* – – – – – – – Zenith Labs
West-Ward* – – – – – – – – West-Ward
Wolins Pharmacal* – – – – – Zenith Labs

Diphenhydramine Expectorant liquid
H.R. Cenci Labs – – – – – – H.R. Cenci Labs
Geneva Generics – – – – – – Bay Labs
Lederle Labs – – – – – – – – National Pharm.
Life Labs – – – – – – – – – Life Labs
McKesson Labs* – – – – – – MK Labs
Parke-Davis – – – – – – – – Parke-Davis
Parmed Pharm. – – – – – – – National Pharm.
or Bay Labs
Penta Products – – – – – – – Life Labs
Purepac – – – – – – – – – – Purepac
Rugby Labs – – – – – – – – Bay Labs, Clay Park Labs
or National Research
Stayner Corp. – – – – – – – Bay Labs
Vangard Labs* – – – – – – – National Pharm.
Wolins Pharmacal* – – – – – National Pharm., Generic
Pharm., Zenith Labs
or Chromalloy Pharm.

Diphenhydramine HCl 25 and 50 mg caps
Barr Labs – – – – – – – – – Barr Labs
H.R. Cenci Labs – – – – – – Cord Labs or Generic Pharm.
Drummer Labs – – – – – – – Lemmon
Geneva Generics – – – – – – Cord Labs
ICN Pharm.* – – – – – – – – ICN Pharm.
Invenex Pharm. – – – – – – – Invenex Pharm.
Ladco Labs – – – – – – – – Rugby Labs[1]
or Chelsea Labs
Lederle Labs – – – – – – – – Barr Labs
or Danbury Pharmacal
McKesson Labs* – – – – – – McKesson Labs
Parke-Davis – – – – – – – – Parke-Davis
Parmed Pharm. – – – – – – – Danbury Pharmacal,
Barr Labs, Zenith Labs
or Cord Labs
Penta Products – – – – – – – Generic Pharm. or Barr Labs
Philips Roxane – – – – – – – Philips Roxane
Purepac – – – – – – – – – – Purepac
Rugby Labs – – – – – – – – Chelsea Labs
Smith Kline & French – – – – Smith Kline & French
Stayner Corp. – – – – – – – Generic Pharm.
Towne, Paulsen & Co. – – – – Towne, Paulsen & Co.
Vangard Labs* – – – – – – – Generic Pharm.
West-Ward* – – – – – – – – West-Ward
Wolins Pharmacal* – – – – – National Pharm., Generic
Pharm., Zenith Labs
or Chromalloy Pharm.

Diphenoxylate HCl 2.5 mg with Atropine Sulfate .025 mg
Barr Labs – – – – – – – – – Barr Labs
Coast Labs – – – – – – – – M.D. Pharm.
Geneva Generics – – – – – – Cord Labs
Lederle Labs – – – – – – – – Barr Labs or Mylan Pharm.
McKesson Labs* – – – – – – Barr Labs
Parmed Pharm. – – – – – – – Cord Labs
Penta Products – – – – – – – Barr Labs
Philips Roxane – – – – – – – Philips Roxane
Purepac – – – – – – – – – – Halsey Drug Co.
Rexall Drug Co. – – – – – – M.D. Pharm.
Rugby Labs – – – – – – – – Chelsea Labs
Searle Pharm. – – – – – – – Searle & Co.
Smith Kline & French – – – – Mylan Pharm.
Stayner Corp. – – – – – – – Philips Roxane

Continued in March Issue

** No response was received from this company. The information listed has been taken from previous articles.*

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[2] Pfizer reports that it holds the patent on this product and says, "No other company has been licensed by Pfizer to manufacture, sell or distribute these products." Since other companies also reported manufacturing or distributing this product we are listing this information but make no representation as to the legitimacy of any seller's claims.

BOB BERGSTEIN
JON JOHNSON

Free at last

Dog work: counting inventory, filing, keeping up-to-date price lists: that's not what we went to school for. But it takes up too many hours in a pharmacist's day. Bob Bergstein and Jon Johnson of the Clinton Pharmacy, Clinton, MD, found the answer in the IBM QS/1 System.

Jon Johnson says, "Our Medicaid volume runs in excess of $10,000 per month, and the turn-around time from submission to cashing of the check has been cut from 34 to nine days. Our Aetna payments are now paid within days against the old system which took almost two months. At 2% a month, the interest on that money alone almost justifies the cost of the machine."

Bob Bergstein concurs. "The QS/1 posts charges and third party plans automatically; prices prescriptions; prints labels — it takes only three seconds to print a refill label," Bob notes.

Call Jon Johnson or Bob Bergstein at the Clinton Pharmacy, (301) 868-2000. They'll give you a free demonstration of the QS/1 on the job. It's easy to lease. Now's the time.

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SUCCESS BREEDS SUCCESS

First there was

SUDAFED

- #1 pharmacist-recommended cold tablets[1]
- More than 401,200,000 tablets sold last year . . . and growing at a rate faster than the market[2]

Then came

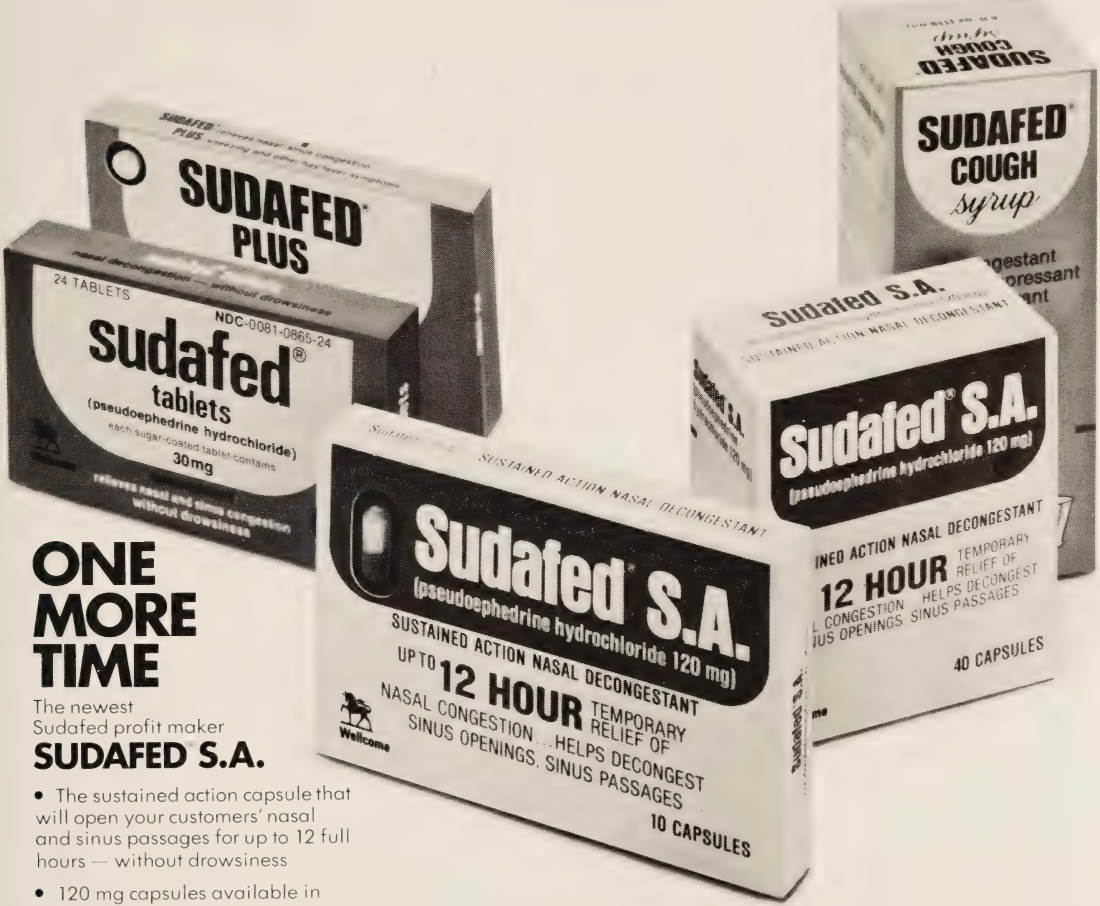
SUDAFED PLUS

- The decongestant with antihistamine really sells . . . thanks to your recommendations
- 55% was purchased because pharmacists recommended it[2]
- 34% of sales are attributable to physicians' recommendations[2]

And then

SUDAFED COUGH SYRUP

- All the best of Sudafed with dextromethorphan and guaifenesin has made this a real buy for customers of Sudafed . . . thanks again to pharmacists' recommendations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each sugar-coated tablet contains 30 mg
relieves nasal and sinus congestion without drowsiness
SUDAFED® COUGH syrup
Sudafed® S.A.
(pseudoephedrine hydrochloride 120 mg)
SUSTAINED ACTION NASAL DECONGESTANT
UP TO 12 HOUR TEMPORARY RELIEF OF NASAL CONGESTION...HELPS DECONGEST SINUS OPENINGS, SINUS PASSAGES
10 CAPSULES
40 CAPSULES
Wellcome

ONE MORE TIME

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Sudafed profit maker

SUDAFED S.A.

- The sustained action capsule that will open your customers' nasal and sinus passages for up to 12 full hours — without drowsiness
- 120 mg capsules available in packages of 10s, 40s and 100s

Display the winners...display the fine family of SUDAFED products to generate customer loyalty and PROFITS for you

References: 1. Open Call Survey, *Am Druggist*, Sept. 1981. 2. Data on file, Burroughs Wellcome Co.

Wellcome
Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Robert J Silverman	Jane M Borne	Peggy M. Jones.	Michael K Spray
University of Michigan	University of Wyoming	University of Wisconsin-Madison	Ferris State College

Remember the summer of '81?

Last summer, four young people joined The Upjohn Company as part of the NPC Pharmacy Internship Program.

They added to their educational process.... learned about manufacturing, quality control, pharmaceutical research, and marketing/sales.

We hope we answered their questions. Certainly, we took their suggestions to heart.

And when the 10 weeks were over, we parted knowing that we'll enjoy seeing each other in the years ahead.

And reminiscing about the summer of '81.

Upjohn

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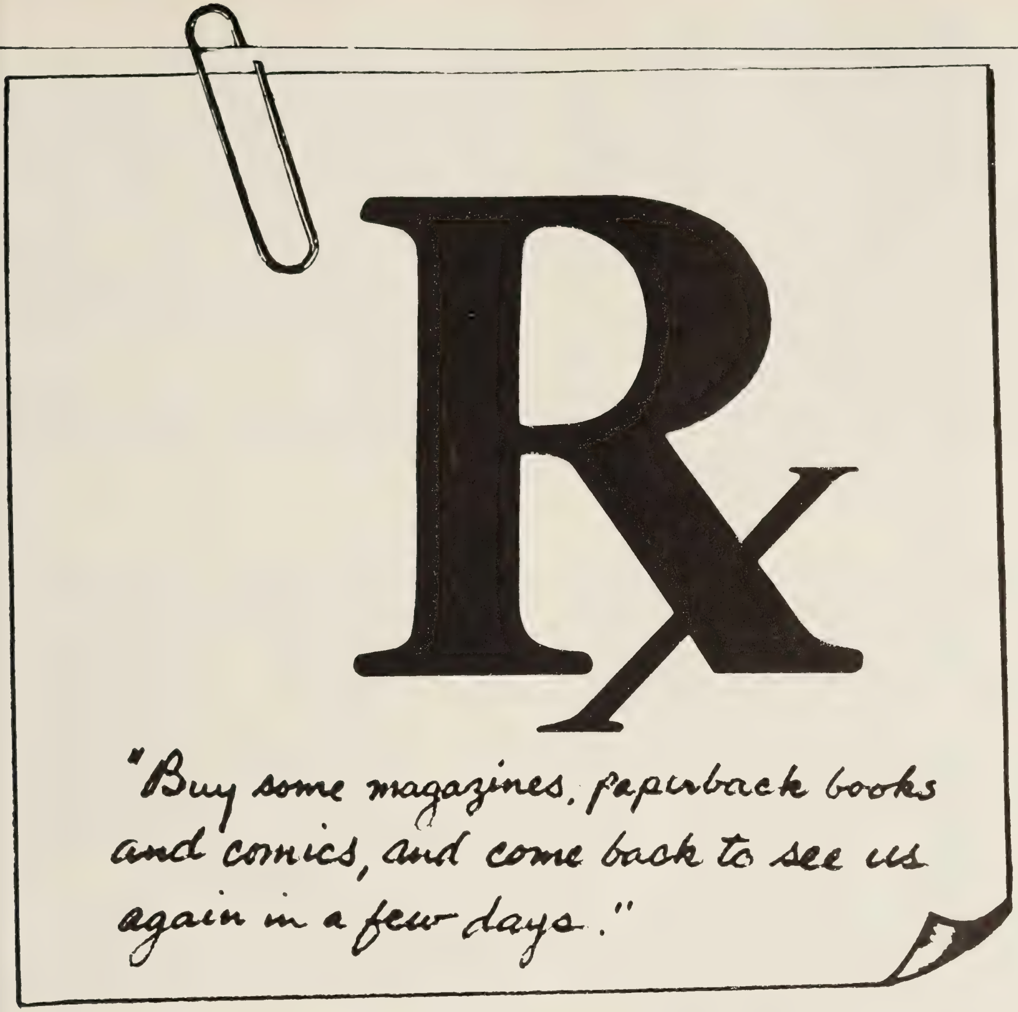
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Maryland Poison Prevention Week

March 21–27, 1982*

Jacquelyn S. Lucy, M.A., M.Ed.
Coordinator, Education/Communications
Maryland Poison Center

According to the Division of Poison Control, the third week in March is March 21–27, 1982 so Maryland Poison Prevention Week (MPPW-'82) has been changed to coincide with the national observance.

As was mentioned in last month's *Maryland Pharmacist,* the Maryland Poison Center (MPC) is again encouraging pharmacists to become actively involved in MPPW-82. Activities, such as increased promotion of Syrup of Ipecac, conducting community poison prevention programs, sponsoring poison prevention poster contests, serve as excellent reminders to the public of their pharmacist's concern for safety.

Since MPPW-82 will focus on the need to treat *all* medicines as potential poisons, it will encourage such behaviors as proper storage, discarding old or outdated medicines, use of safety closures by parents of small children, etc. Since a common misconception exists that over-the-counter drugs are not harmful except in massive overdose, many people do not apply common safety precautions when using or storing these items. Non-prescription medicines, such as vitamins, have even been used by parents as "rewards" for positive behavior.

The MPC recognizes the pharmacist as the best source of consumer drug information. Therefore, as part of our public education program, we advise the public to consult their pharmacist when they have questions pertaining to proper storage and usage of medicines, their common side effects, as well as to the proper selection of OTC drugs.

If you are a preceptor, MPPW-82 offers an excellent opportunity for involving your student in this drug information and poison prevention role.

Obviously, all poison-related exposures or inquiries should be referred to the MPC. In 1981, the MPC staff handled over 47,000 poison-realted calls. Since we usually have a single pharmacist or pharmacy student on duty, we are unable to handle referrals concerning general drug information. Also, during MPPW, we will be stressing that the Maryland Poison Center is a specialty medical unit designed to deal specifically with poisons and poisonings and is *not* a general health hotline. Your continued support in "spreading the word" will be gratefully appreciated.

If you have any questions or comments about MPPW-82, please contact me at (301) 528-7184.

As part of the Centennial Celebration, the Association is expanding exposure of the Kelly Memorial Building to public tours.

Several recent groups of grade school students have toured the B. Olive Cole Museum housed in the Kelly Building.

Samuel Lichter (left), Chairman of the Board, and Philip Cogan (right), President, are shown signing the special membership certificates which are being given to each member of the Association during the 1982 celebration. Handsome mounting kits are available from the Association (see page 31) so members might display the certificate.

David Banta, Executive Director, holds an old prescription file which is part of the historic display found in the lower level of the Kelly Building. SAPhA students are continuing the restoration of this section of the museum.

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Part of a continuing series on today's pharmacy

Perspectives in Pharmacy

Patient Drug Information

Presented
in the interest of
better-informed
pharmacy

Neil L. Pruitt, R.Ph., President
National Association of Retail Druggists

"The delivery of health care in our communities is changing. Traditional institutions are giving way to home health care and outpatient clinics. Handicapped persons with their special needs for durable medical equipment and health supports and appliances require personal attention. The increase in over-the-counter products that were once prescription-only means that more customers will require counseling on their use. An increasing drug-dependent elderly population will rely more than ever on the professional advice of their pharmacists.

Neil L. Pruitt, R Ph

"Patient counseling will become more important than ever before because of the hosts of different populations we are seeing in our stores—the handicapped, the elderly, the teenager who has more money to spend on cosmetics, the consumer who wants to know about the efficacy of the drugs he or she is taking.

"Talking to our customers gives us a unique marketing advantage because we know who they are and what they want. Service is, indeed, one of our keys for survival."

Dorothy L. Smith, Pharm.D.
Director of Clinical Affairs
American Pharmaceutical Association

"The pharmacist has an excellent opportunity to test the patient's recall of the information provided by the physician, to make the prescription instructions readily understandable, and to reinforce the patient's faith in the prescribed therapy.

Dorothy L. Smith, Pharm.D.

"The type and amount of information required will vary with the specific needs of the patient. But generally, patients want enough information to help them complete the therapy *as easily* and *as safely* as possible.

"Almost all patients will have questions about applying the drug regimen to their own schedules. They are willing to modify their daily activities to accommodate a dosage schedule if they understand why the changes are best for them. But these questions can be answered only on an individual basis.

"Handing the patient a full disclosure sheet does not effectively help 'educate.' In fact, a long list of potential adverse effects may even convince a patient *not* to take the medication.

"Every effort must be made not to frighten the patient. Basically, the role of the pharmacist is to help a patient use drugs most effectively and with the least anxiety."

Reprinted from American Pharmacy, Vol. NS 21, No. 7, p. 382.

John F. Schlegel, Pharm.D., M.S.
Executive Director
American Association of Colleges of Pharmacy

"Most pharmacy professionals recognize the importance of communication skills. Indeed, depending on one's particular perspective, personal pharmacy service that emphasizes patient education can be a source of immense satisfaction, enhanced professional image, increased patronage, and improved health care through better understanding and use of medicines.

John F. Schlegel, Pharm.D., M.S.

"Influences both inside and outside the profession point toward a resurgence of personal contact between the pharmacist and the patient. The public's 'right to know' cannot responsibly be denied. The problem has been in finding time in the pharmacy student's busy curriculum for proper communication skills training.

"For the past several years, colleges of pharmacy have been increasing the quantity and quality of training in this area, and greater attention is being paid to the influence of personality types on professional motivation.

"In the future, the 1980's will likely be described as the 'Communications Era' in pharmacy. The profession has made significant advances, but there is still a need for more change."

Lilly

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If the only two certainties are death and taxes then the new IRS inflated penalties for late payment of taxes is certain to make life more difficult. Pharmacists who need to remind themselves or their accountants of the important Share the Wealth with Uncle deadlines should post this chart for reference.

Taxes that are due four or more times during the year are identified by key letters which are explained below the chart. Note that if a tax is due on a weekend or holiday the due date is advanced to the next business day, causing some taxes due the last of a month to be payable early the next month.

JANUARY 1982

Wednesday January 6	FD(a)
Monday January 18	FI
Thursday January 21	ST

FEBRUARY 1982

Monday February 1	FQ, FU, SQ, SU, FD
Wednesday February 3	FD(a)
Tuesday February 16	FD(b), SD,
Monday February 22	ST

MARCH 1982

Wednesday March 3	FD(a)
Monday March 15	FD(b), SD Calendar year corporations must file income tax return or pay 50% of unpaid taxes and file for 3 months automatic extension. Acrual basis corporations must declare accrued expenses by this date (2½ months after end of taxable year)
Monday March 21	ST

APRIL 1982

Monday April 5	FD(a)
Thursday April 15	Federal and state income tax due or you must pay estimated amount due and file for 60 day extension. Interest will be due on amount paid after April 15. State corporation tax due. 60 day extension may be requested. State personal income tax due. FC/P, FI
Wednesday April 21	ST
Friday April 30	FQ, FU, SQ, SU, FD

MAY 1982

Wednesday May 5	FD(a)
Monday May 17	FD(b), SD
Friday May 21	ST

JUNE 1982

Thursday June 3	FD(a)
Tuesday June 15	FD(b), SD, FC/P, FI State & Federal individual, partnership, and corporation taxes due with interest if extension had been granted.
Monday June 21	ST

JULY 1982

Tuesday July 6	FD(a)
Wednesday July 21	ST

AUGUST 1982

Monday August 2	FQ, FU, SQ, SU, FD
Wednesday August 4	FD(a)
Monday August 16	FD(b), SD
Monday August 23	ST

SEPTEMBER 1982

Friday September 3	FD(a)
Wednesday September 15	FD(b), SD, FC/P, FI
Tuesday September 21	ST

OCTOBER 1982

Monday October 4	FD(a)
Thursday October 21	ST

NOVEMBER 1982

Monday November 1	FQ, FU, SQ, SU, FD
Wednesday November 3	FD(a)
Monday November 15	FD(b), SD
Monday November 22	ST

DECEMBER 1982

Friday December 3	FD(a)
Wednesday December 15	FD(b), SD, FC/P
Tuesday December 21	ST

FD(a)	Last payment due on Federal income and social security taxes withheld during the previous month if over $3000 was withheld. You are required to deposit the amount withheld within 3 banking days after you reach $3000 at the end of any eighth-monthly period (these periods end on the 3rd, 7th, 11th, 15th, 19th, 22nd, 25th, and last day of the month)
FD(b)	Federal income and social security taxes withheld must be deposited by this date if between $500 and $3000 was withheld during the previous month.
FQ	Federal Quarterly income and social security taxes withheld must be paid.
FU	Federal Unemployment tax must be paid.
FC/P	Federal estimated corporation and partnership taxes must be paid if on calendar basis (note—fiscal year corporations pay this tax on 15th day of 4th, 6th, 9th, and 12th month of their year)
FI	Federal estimated individual tax for previous quarter due.
FD	Federal social security and withholding tax if any due domestic workers.
ST	Maryland State Sales Tax due.
SQ	Maryland State income tax withheld due for previous quarter.
SU	Maryland State Unemployment taxes due.
SD	Maryland State estimate of income tax withheld the preceeding month must be deposited.

NOMINATIONS

The Awards Committee of the Maryland Pharmaceutical Association is soliciting nominations from the membership for two prestigious awards which are presented to pharmacists at the Annual Banquet. Since this is a special year due to the Centennial Celebration, the Committee decided that more membership input into the Awards process would be appropriate. The two Awards are:

BOWL OF HYGEIA This award is presented annually through the cooperation of the A. H. Robins Co. to a pharmacist who has compiled an impressive record in the area of community service.

MPhA Achievement Award This recently instituted award is given to a pharmacist who is distinguished in the area of contributions to the profession of Pharmacy.

Nominations for either of these two awards may be sent to the Awards Committee for consideration. Nominations must be in writing and should outline the qualifications of the individual for the award being considered. Nominations are kept on file each year and may be considered by the Awards Committee in future years. Nominations or inquiries about the nominating process should be sent to the M.Ph.A., 650 W. Lombard Street, Baltimore, Maryland 21201.

RESOLUTIONS

The Vice Speaker of the House of Delegates, Jim Terborg, also serves as Chairman of the Association's Resolutions Committee. The Committee will be meeting soon to consider issues and resolutions for the Annual Convention of the Association, June 20–24, 1982 in Ocean City, Maryland. In order to allow for greater membership participation in the resolution process which forms the basic policy making structure of the Association, the Committee is soliciting input from the membership in the form of suggested resolutions or resolution topics. Resolutions may be sent to the Association at this time with any background or supporting information necessary. They should be sent to the M.Ph.A. Resolutions committee, 650 West Lombard St., Baltimore, Md. 21201.

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LETTERS

Dear Dave:

I do not know about the rest of Maryland Pharmacists but I am mad as hell at PAID prescriptions over their recent announcement to third party administrators that they have a mail-order prescription drug service available to allegedly help them hold down prescription drug costs.

I remember in the late 1960's when these third parties came out and begged pharmacists to participate in their plans. Over the years they have prospered by selling OUR services to their customers. They have profited because we have agreed to go along with their plans, often to our great harm.

Now PAID, which owes its very existence to community pharmacists, stabs us in the back by offering this mail-order scheme to the world. All these years they have claimed to be the friend of the pharmacist and only in business to help us and the recipient receive quality health care. This action on their part once again shows that these people hold us in complete contempt.

I personally am going to reevaluate my participation in their program. I can no longer continue to support an organization which clearly intends to help put me out of business through their own selfishness.

Sincerely,
Paul Zucker

Dear Mr. Cogan:

As Vice President of Pharmacy Operations for Rite Aid Corporation, I would like to respond to your editorial in the October, 1981 edition of the Maryland Pharmacist. In your article you asked for input regarding the desirability of Maryland enacting mandatory continuing education legislation.

I wish to state that while I support the concept of continuing education, I am strongly opposed to any legislation which would mandate this process. I am opposed in that our company currently operates stores in states which mandate continuing education and observe no noticeable difference in the quality of pharmaceutical care delivered by *all pharmacists* in those states where it is not. What we have observed is the enactment of a cumbersome and expensive set of procedures which are a burden to all pharmacists.

Our company currently provides several types of continuing education to its pharmacists on a voluntary basis. In addition, many other forms of continuing education are available from other sources throughout the State of Maryland. Those pharmacists so inclined as to pursue this additional knowledge have ample opportunity to partake in continuing education programs.

I believe that those pharmacists not inclined to participation in continuing education on a voluntary basis will get little or nothing out of it under a mandatory system. Instead pharmacists will be forced to expend money and effort to "go through the motion" of fulfilling yet another regulatory hurdle.

In addition I have reviewed many of the programs currently offered in the states where continuing education is mandated. I find that a great many of the programs offered have little or no applicability or value to the typical community pharmacist.

In addition, the cost of these programs has steadily risen in those states where continuing education is mandated. I must question whether or not the extra cost and inconvenience imposed upon the typical community pharmacist can be balanced against an equal or greater improvement in his or her standard of practice.

It is my belief that because of the reasons stated above, the typical community pharmacist in Maryland should continue to support continuing education on a voluntary basis only.

Thank you for giving me an opportunity to comment on this matter and please feel free to contact me should you wish to discuss this subject any further.

Very truly yours,
RITE AID CORPORATION
Alex Schamroth
Vice President
Pharmacy Operations

Dear Dave:

The Maryland Society of Hospital Pharmacists will hold their 17th Annual Seminar in Williamsburg, Virginia on June 18, 19 & 20. For more information, please contact Normand Pelissier, Chairperson Seminar Committee, C/O The Union Memorial Hospital, 201 East University Parkway, Baltimore, Maryland 21218.

Sincerely,
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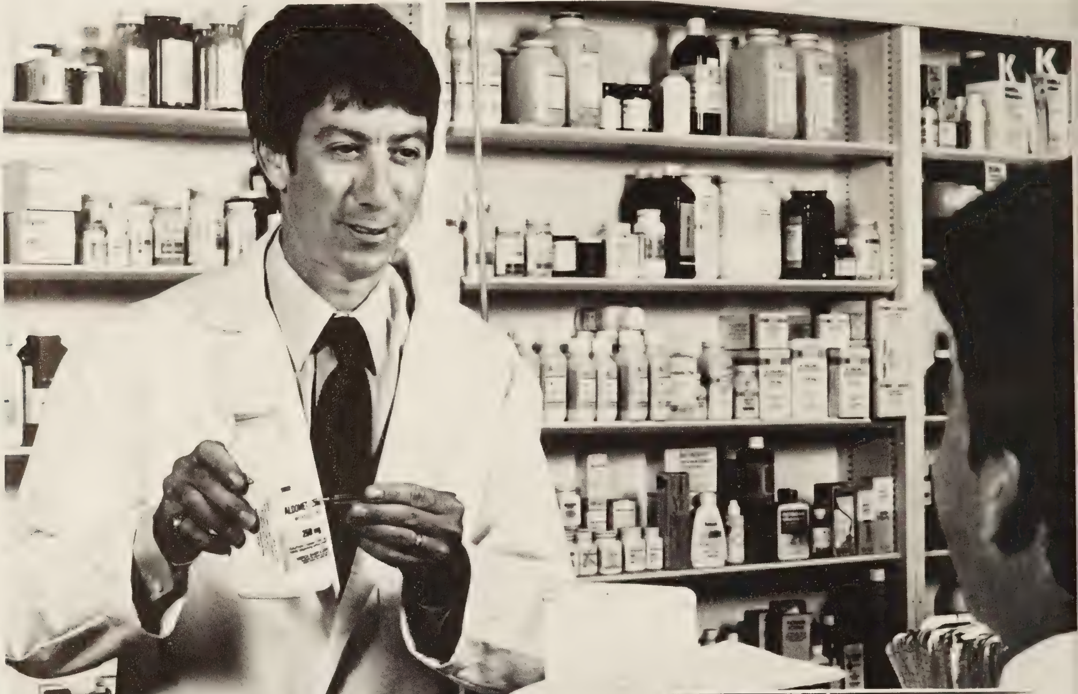

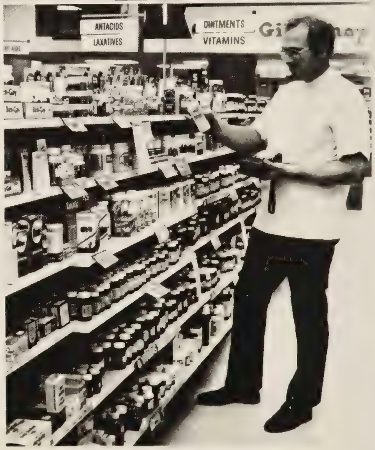

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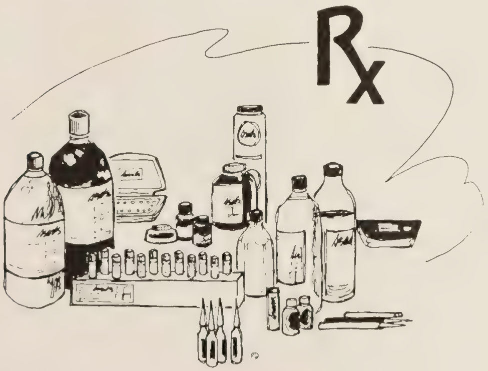
* Each 1982 member of the Association is receiving a special Centennial membership certificate. These certificates are sent at no additional charge as 1982 dues are paid. Contact the office if you have a question about this certificate.

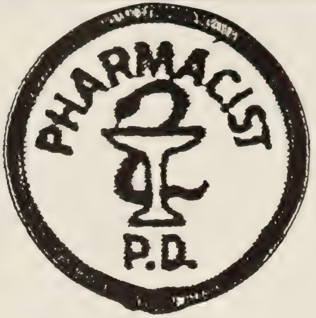
* Special offer. A Mounting and display kit available from the Association for displaying your Centennial Certificate. $15.00 each from the Association office.

* The M.Ph.A. is offering to the public and its members the USP publication, "About your Medicine." This 400 page reference book covers the top 200 commonly used medicines. $4.50 each plus $1.00 for postage etc. from the Association office. Also available—"About your High Blood Pressure Medicine"—$3.00 each plus $1.00 postage and handling.

* The Pharmacy Art Print "Secundem Artem" is available from the Association office. This 18" × 24" full color print is only $25.00 plus $3.00 for shipping and handling.

* Centennial Apothecary Jars with the Association's historic banner displayed is available for only $12.00 each which includes handling. Quantity discounts are available and it makes an excellent gift.





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THE
MARYLAND
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March, 1982
VOL. 58
NO. 3

Cephalosporins: New Third Generation Antibiotics

— Gerald Herpel

Maryland College of Pharmacy and the Doctor of Pharmacy Degree

— B. F. Allen, Ph.D.

Third Party Reference Chart

Plan Now to Attend the Centennial Convention
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MARCH, 1982 VOL. 58 NO. 3

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President's Message

Continuing with our Centennial Theme, "Remembering Where We've Been/Deciding Where We're Going", the upcoming Spring Regional Meeting will give all Maryland Pharmacists a chance to influence the direction of the Association. For those of you who are not aware, the Association has three major business or policy formulating meetings each year. The first is the Spring Regional, which will be held this year on March 28th at the MPhA Headquarters, the Kelly Memorial Building in Baltimore. The second is the Annual Convention, this year to be held in June at the Carousel Hotel in Ocean City. And, the third is the Fall Regional, which will take place at a location to be announced.

Decisions are made by the House of Delegates, but all members have the opportunity to voice their opinions and participate in deliberations. The delegates are selected by the local associations and other affiliated or recognized organizations.

We sincerely hope that as many pharmacists as possible will attend the Spring Regional meeting this year. In addition to the business session, the Centennial Committee has planned a brief program. As part of our Centennial Celebration, a plaque will be dedicated to commemorate two distinguished Maryland pharmacists, who were pioneers in the profession, James Proctor and David Stewart. We will have a short reception to welcome the dignitaries and new members and encourage attendees to tour the Kelly Memorial Building and the B. Olive Cole Pharmacy Museum. The remainder of the program will feature a forum to openly discuss issues relating to our future. A panel of current leaders in Maryland's pharmacy organizations will explore, with the attendees, such issues as: should we or should we not support mandatory continuing education as a requisite for relicensure; should there be a closer affiliation arrangement among pharmacy organizations in the State?; should nurse practitioners be allowed to prescribe drugs?; should pharmacists be allowed to prescribe?; would the pharmacists support a curriculum for an advanced pharmacy degree outside the traditional school hours; and, should third party payors for prescriptions be regulated by the State Insurance Board? I'm sure you can suggest many more issues. Please come to the Spring Regional Meeting so that your views may be heard and you may help decide our future.

Philip H Cogan

Philip H. Cogan,

President

Cephalosporins: New Third Generation Beta-Lactamase Resistant Antibiotics

by Gerard Herpel

Cephalosporins are a growing class of antibiotics. The new numbers of the class have an enhanced spectrum against previously resistant strains of bacteria. They are considered to be a desirable class of antibiotics since their toxicities are very low as compared with the aminoglycosides and other antibiotics active against gram-negative bacteria. Recently, there has been a need for antibiotics which are not destroyed by betalactamases produced by various resistant organisms.[3,14,15]

Beta-lactamases are enzymes produced by bacteria capable of inactivating penicillins and cephalosporins. These enzymes hydrolyze lhe beta-lactamase ring (Fig. 1) rendering the antibiotic inactive. However, the correlation between antimicrobial resistance and beta-lactamase production is not perfect. Some bacterial strains that fail to hydrolyze the cephalosporins are still resistant to them; and vice versa, some bacteria which hydrolyze the cephalosporins are still killed by them (Goodman & Gilman, *p*1152). Cephalosporins vary in their susceptability to beta-lactamases. As will be discussed later, the new cephalosporins are more active against beta-lactamase producing bacteria and present new alternatives for use against resistant organisms.

The following paper will outline the first and second generation of cephalosporins that are already on the market and being used clinically, followed by a detailed discussion of the third generation of cephalosporins.

I) First Generation (Beta-lactamase Sensitive)

A) Parenterals

There are four commercially available products in this group: (1) Cephalothin (Keflin®), (2) Cephapirin (Cefadyl®), (3) Cefazolin (Ancef®, Kefzol®), and Cephaloridine (Loridine®).

Spectrum

These cephalosporins are active against 90% of the following bacteria:

1) Staphylococcus aureus (penicillase producing)[a]
2) Staphylococcus species
3) Streptococcus species[b]
4) Escherichia coli
5) Proteus mirabilis
6) Klebsiella pneumoniae

These cephalosporins are less reliably active against the following organisms and sensitivity tests must be performed before their use:

1) Neisseria gonorrhea
2) Haemophilus influenzae
3) Salmonella
4) Shigella

They are inactive against the following bacteria:

1) Streptococcus faecalis
2) Pseudomonas aeruginosa
3) Enterobacter
4) Indole-positive proteus (i.e., Proteus vulgaris)
5) Serratia marcescens

Side Effects

The side effects of these cephalosporins are few and include; (1) Some cross allergenicity in patients allergic to penicillins; (2) Cephalothin and Cephapirin cause pain on injection and possible thrombophlebitis; (3) Cephalothin has been shown to possibly increase the nephro-toxicity of the aminoglycosides[23]; and (4) Cephaloridine has a high incidence of nephro-toxicity; therefore, it is not recommended for general use.

B) Oral Medication

There are four available cephalosporins which are stable to oral absorption: (1) Cephalexin (Keflex®), (2) Cefaclor (Ceclor®), (3) Cefadroxil (Duricef®), and (4) Cephradine (Anspor®, Velosef®).

Gerald Herpel is a graduating Pharmacy student at the University of Maryland School of Pharmacy.

[a] Cefazolin is more sensitive to penicillinase produced by Staphylococci and is not active against 90% of these bacteria (G & G, p. 1154).

[b] Except enterococci, i.e., S. Faecalis

Spectrum

All four of these oral cephalosporins are similar in activity to cephalothin except that they have less activity against penicillinase-producing Staphylococci. However, cefaclor is more active than the others against gram-negative bacilli, (i.e., H. influezae, E. coli, and Proteus mirabilis). It is especially useful in otitis media and upper repiratory infections caused by these organisms (G & G, p1156).

Side Effects

The side effects are minor. There is a high incidence of GI distress and administration with food will decrease the absorption. Also, there is the possible cross allergenicity with the penicillins.

II) Second Generation (Beta-lactamase Resistant)

The cephalosporins of this class have an increased activity against gram-negative organisms due to a greater stability to beta-lactamase produced by the gram-negative organisms. These parenteral formulations show a decreased activity against the gram-positive organisms than the older cephalosporins but can still be used in most situations where gram-positive coverage is required. Cefamandole (Mandol®), Cefoxitin (Mefoxin®) and Cefuroxime are the three drugs of this class most commonly used.

Spectrum

The second generation cephalosporins are active against:

1) Haemophilus influenzae
2) Enterobacter
3) Indole-positive Proteus (i.e., Proteus vulgaris)
4) Serratia marcescens
5) Bacteroides
6) Neisseria gonorrhea[c]
7) Salmonella

They are not as active against gram as the first generation cephalosporins positive organisms. Like the first generation cephalosporins, they are inactive against Pseudomonas and Streptococcal faecalis.

The use of these cephalosporins should be confined to specific organisms in which high activity occurs. This will reduce the chance of resistant strains forming. Cefamandole is indicated for infections caused by Enterobacter, Haemophilus influenzae, and Salmonella. Cefoxitin is indicated in Bacteriodes infections, and Cefuroxime is the cephalosporin of choice in Neisseria gonorrhea and is almost as active as ampicillin.[1] None of the cephalosporins will cross the meninges, even when they are inflammed, in sufficient amounts to reliably treat meningitis.

Side Effects

The side effects are those common to other cephalosporins, such as allergic reactions and cross allergenicity with the penicillins. Cefamandole and cefuroxime have a low incidence of pain and phlebitis upon injection; but cefoxitin does cause pain and possible phlebitis upon injection.

III) Third Generation (Beta-lactamase resistant)

The third generation cephalosporins have an even greater activity against beta-lactamase producing gram-negative organisms. The most notable increase in activity is against Pseudomonas aeruginosa. They are not as active against gram positive organisms as the older cephalosporins, but do have good activity against penicillinase-producing and methicillin-resistant Staphylococcus aureus (see table 1)[d]

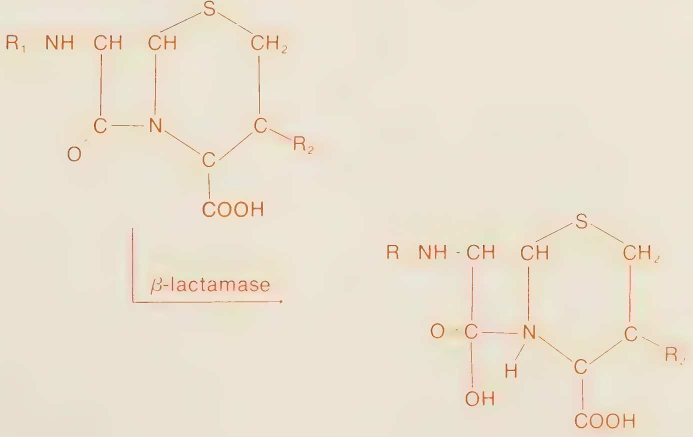

Figure 1

---

[c] Much better activity than cephalothin.

[d] Table 1 lists five of the new third generation cephalosporins and their activity against various organisms. The minimum inhibitory concentration (mcg/ml) for each drug by which 50% and 90% of all strains were inhibited is compiled, as well as the standard deviation (T^{n-1}) and ranges of MIC's observed.

TABLE I

Organism		(CFT) Cefotaxime MIC (st dev) (range)		(CPZ) Cefoperazone MIC (st dev) (range)		(MOX) Moxalactam MIC (st dev) (range)	
		50%	90%	50%	90%	50%	90%
Pseudomonas aeruginosa	MIC	16.1 (7.6)	52.8 (35.0)	4.8 (2.2)	24.9 (9.8)	13.5 (3.0)	62 (32.4)
	range	(8–32)	(16–128)	(4–8)	(12.5–32)	(8–16)	(32–>100)
Serratia marcescens	MIC	0.325 (0.137)	13.8 (21.8)	14.9 (23.7)	56.0 (53.1)	0.45 (0.13)	9.9 (18.0)
	range	(0.25–0.50)	(0.25–500)	(0.5–50)	(16–100)	(0.25–0.6)	(0.12–50)
Klebsiella pneumoniae	MIC	0.18 (0.21)	0.21 (0.13)	1.51 (1.72)	46.8 (58.3)	0.27 (0.17)	0.90 (0.49)
	range	(0.02–0.5)	(0.06–0.5)	(0.25–4.0)	(1.0–128)	(0.10–0.50)	(0.25–1.6)
Proteus mirabilis	MIC	0.092 (0.18)	0.12 (0.18)	0.64 (0.44)	1.21 (1.31)	0.23 (0.21)	0.25 (0.18)
	range	(0.0063–0.5)	(0.015–0.5)	(0.12–2.0)	(0.25–3.1)	(0.06–0.5)	(0.12–0.50)
Indole-positive *Proteus*	MIC	0.16 (0.20)	1.50 (2.5)	1.04 (0.94)	4.08 (3.88)	0.21 (0.18)	0.44 (0.32)
	range	(0.03–0.50)	(0.03–8.0)	(0.12–2.0)	(0.25–80)	(0.03–0.5)	(0.25–1.0)
Staphylococcus aureus (Penicillinase problems)	MIC	2.4 (1.1)	2.59 (1.25)	1.4 (0.8)	3.55 (0.64)	8.0	8.0
	range	(1.6–4.0)	(0.5–3.1)	(0.8–2.0)	(3.1–4.0)		
Staphylococcus aureus (Methicillin resis.)	MIC	48.7 (69.1)	64.1 (63.0)	2.0	4.0	16.0	16.0
	range	(2.0–128)	(2–>128)				
Streptococcus pyogenes	MIC	0.035 (0.0247)	0.065 (0.50)	0.06	0.12	1.0	2.0
	range	(0.03–0.05)	(0.03–0.10)				
Streptococcus faecalis	MIC	128	>128	28.5 (4.9)	96 (45)	>128	>128
	range			(25–32)	(64–>100)		
Neisseria gonorrhea	MIC	<0.001	0.04 (0.064)	0.01	0.16 (0.13)	—	—
	range		(0.01–0.12)		(0.06–0.25)		
E. coli	MIC	0.18 (0.15)	0.23 (0.14)	0.34 (0.20)	17.7 (28.0)	0.27 (0.21)	0.32 (0.17)
	range	(50.03–0.5)	(0.06–0.50)	(0.12–0.50)	(1.0–50.0)	(0.06–0.50)	(0.12–0.50)
Enterobacter	MIC	0.21 (0.15)	1.96 (3.09)	0.20	0.50	0.19 (0.18)	0.39 (0.36)
	range	(0.04–0.40)	(0.12–8.0)			(0.06–0.40)	(0.12–0.80)
Citrobacter species	MIC	5.7 (4.0)	48.0 (27.7)	8.0	32.0	8.0	64.0
	range	(1.0–8.0)	(16.0–64.0)				
Haemophilus influenzae	MIC	0.015	0.19 (0.39)	—	0.50	—	0.06
	range		(0.03–0.80)				
Salmonella	MIC	0.085 (0.05)	0.17 (0.07)	0.40	25.0	—	—
	range	(0.05–0.12)	(0.10–0.25)				
Bactoroides	MIC	25.0	64.0	25.0	100.0	—	—

TABLE I (Continued)

Organism		(CFS) Cefsulodin MIC (st dev) (range) 50%	90%	(CTZ) Ceftizoxme MIC (st dev) (range) 50%	90%
Pseudomonas aeruginosa	MIC	3.0 (1.4)	32.7 (15.2)	12.5	58
	range	(2.0–4.0)	(16–50)		(16–100)
Serratia marcescens	MIC	—	>400	—	0.12
	range				
Klebsiella pneumoniae	MIC	—	>400	0.02	0.02 (.014)
	range				(0.02–0.05)
Proteus mirabilis	MIC	—	>400	≤0.0063	0.032 (0.046)
	range				(≤0.0063–0.06)
Indole-positive *Proteus*	MIC	—	200	0.02	6.3
	range				
Staphylococcus aureus (Penicillinase problems)	MIC	—		—	
	range	—		—	
Staphylococcus aureus (Methicillin resis.)	MIC	—		—	
	range	—		—	
Streptococcus pyogenes	MIC	—	6.3	0.058 (0.06)	0.225 (0.035)
	range			(0.015–0.10)	(0.20–0.25)
Streptococcus faecalis	MIC	—	>900	1.6	>100
	range				
Neisseria gonorrhea	MIC	—	—	0.20	1.60
	range				
E. coli	MIC	—	100	0.20	0.11 (0.13)
	range				(0.025–0.25)
Enterobacter	MIC	—	>400	0.02	0.12
	range				
Citrobacter species	MIC	32.0	128.0	—	—
	range				
Haemophilus influenzae	MIC	—	—	0.05	1.0
	range				
Salmonella	MIC	—	50.0	0.02	0.04 (0.01)
	range				(0.03–0.05)
Bactoroides	MIC	—	—	3.1	25.0

A) Cefotaxime

Cefotaxime is active against the following:

1) Enterobacteriaceae (E. coli, Klebisiella, Proteus)
2) Haemophilus influenzae
3) Pseudomonas
4) Serratia marcescens
5) Neisseria gonorrhea (beta-lactamase producing)[e]
6) Salmonella[f]

Cefotaxime was shown practically equal to cefamandole in activity against Haemophilus influenzae, including ampicillin resistant strains[1,13]. Cefotaxime is not active against Streptococcus faecalis and was not as active as cefamandole and the other third generation cephalosporins against resistant strains of Staphylococcus aureus[4]. Also, compared with other third generation cephalosporins, its anti-pseudomonal activity is lower.

Its side effects are infrequent and minor. Cases of rashes (3.0%)[2], diarrhea and loose stools (0.5%)[2,10], phlebitis (1.3%)[2], and fatique[20] have been reported. Invitro studies have shown very low MIC's, however, suprisingly, high doses are needed therapeutically despite this activity[2,20].

B) Moxalactam

Moxalactam is not a true cephalosporin in that an oxygen is substituted for the sulfur at the one position (oxa-beta-lactam). Its spectrum is very broad including Pseudomonas, all species of Enterobacteriace and anaerobes, including Bacteroides fragilis. Moxalactam was found to be more active against Bacteroides than cefoxitine and cefotaxime[21]. It is the best third generation cephalosporin against Haemophilus influenzae[3] and in one test was shown to be better than cefamandole[1]. Moxalactam is also a good alternative to erythromycin against Legionella pneumophilia[5].

Moxalactam is also different from other cephalosporins in that achievable therapeutic levels in the cerebrospinal fluid can be obtained[11,16]. It crosses only the inflammed meninges and obtains levels of 20-80% of serum levels, which are sufficient to inhibit Neisseria meningitis[11]. Therefore, CSF levels must be closely monitored.

Moxalactam is a good alternative to the aminoglycosides in that its activity is almost equal to the aminoglycosides but has fewer toxicities and side effects[6]. Its side effects are few and less severe than the older cephalosporins. These include skin rashes, fever, and nausea[6,20,21].

C) Cefaperazone

This broad spectrum cephalosporin has the lowest MIC's of all the new third generation cephalosporins against Pseudomonus[8,9,10,12]. It is also active against Enterobacter, Indole-positive Proteus, Serratia marcescens, Methicillin resistant Staphylococcus aureus, and many gram-positive strains that have become resistant to other beta-lactam antibiotics. It is also a good alternative to erythromycin for Legionella pneumophilia. Cefoperazone obtains high serum levels, has high protein binding rates, and has a long biological half life comparable to that of cefazolin.

D) Cefsulodin

Cefsulodin has a narrow spectrum of Pseudomonas, Staphylococcus aureus, and Streptococcus pyogenes[13,14,22]. It showed no activity against any other organism tested. It is highly effective against Pseudomonas and is almost equal in activity to Cefoperazone. It is as active as gentamicin and tobramycin but without the side effects associated with the aminoglycosides[18,22].

E) Ceftroxime

Ceftroxime has a broad spectrum which includes Bactoroides, Citrobacter, Serratia, Enterobacter, Proteus mirabilis, Klebsiella pneumoniae, E. coli, Salmonella, and all gram-positives tested. Ceftroxime is four times as active as cefotaxime against Salmonella and was twice as effective against ampicillin resistant Haemophilus influenzae as cefotaxime[7]. It is the best third generation cephalosporin against Serratia marcescens[15].

F) Cefotiam

Cefotiam is another broad spectrum antibiotic which has activity against Staphylococcus, Streptococcus, Enterobacter, Neisseria gonorrhea, Neisseria meningitis, and Haemophilus influenzae. It has poor activity against Streptococcus faecalis and is inactive against Pseudomonus.

G) Ro-13-9904 (Roche product)[17]

This is a broad spectrum cephalosporin similar in activity to cefotaxime and moxalactam. It is active against Bacteroides fragilis, methicillin resistant Staphylococcus, Streptococcus faecalis, and some of the Pseudomonas species. It is more active than the other two against Haemophilus influenzae and Neisseria gonorrhae.

IV) Conclusion

The new third generation cephalosporin are an important improvement over the older ones. The most note worthy improvement is their activity against Pseudomonas and other gram-negative organisms compared to the aminoglycosides. They, therefore, may prove to be good alternatives to aminoglycosides due to their low toxicities.

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[e] 100-1000 times more active than cefoxitin[1].

[f] 30 times more active than cefoxitin[13].

Acknowledgement

A special thanks to Jerri Formica who allowed me to use her paper "New Antibiotic" which was written 3/11/81 for her Advanced Antibiotics course at the University of Maryland, School of Pharmacy. Her paper provided the basis for this paper.

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Board of Pharmacy Policy on Supportive Personnel

The Board of Pharmacy has an obligation to regulate professional practice to the extent necessary to insure public safety through competently performed pharmaceutical services by licensed pharmacists responsible for assuring the quality of these services to patients.

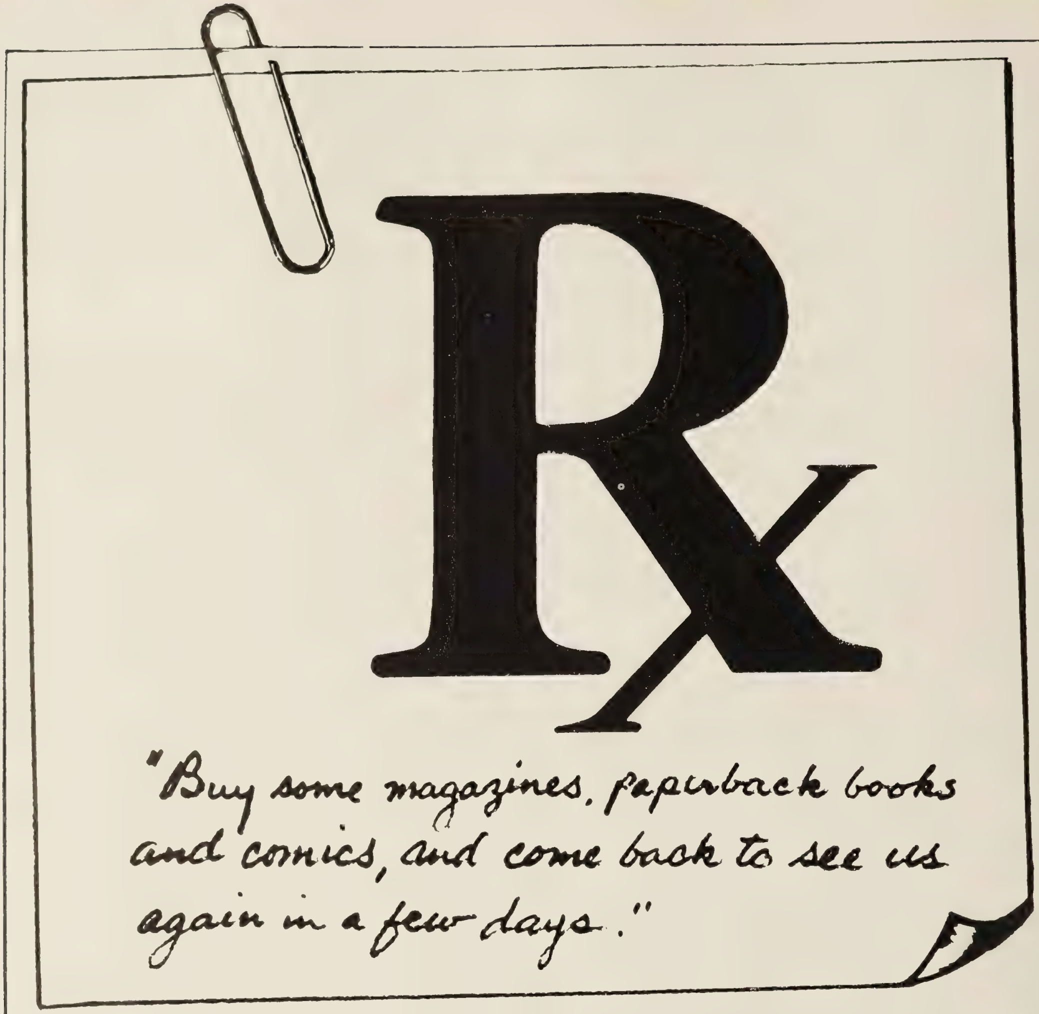
Supportive personnel can assist the pharmacist in the delivery of more meaningful, direct patient services. These individuals shall be trained and qualified according to the standards set by the responsible pharmacist (i.e., Pharmacist in Charge) to perform routine functions which do not require the use of professional judgement, in connection with the preparing, compounding, distributing, dispensing, and administration of medications.

Written control procedures and guidelines for the supervision of supportive personnel by a licensed pharmacist, and for the performance of tasks by these individuals shall be established by the responsible pharmacist (i.e., Pharmacist in Charge) who utilizes them in his/her practice.

Fine is President of ASCP

Jerome L. Fine of Baltimore, Maryland, was installed as 1982 President of the American Society of Consultant Pharmacists at ceremonies held in Phoenix, Arizona during the Society's 12th Annual Meeting. Mr. Fine was elected in October, 1980 by the ASCP membership and served as President-Elect of the Society during the past year. He is a full-time consultant pharmacist for MSC, a national multi-facility nursing home organization.

Other officers installed by Immediate Past President Milton Moskowitz were President-Elect Steven B. Loevner of Edgemont, Pennsylvania and Vice President Elliott Tertes of Plainville, Connecticut.



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Maryland College of Pharmacy and the Doctor of Pharmacy Degree

by B. F. Allen, Ph.D.

The Maryland College of Pharmacy was organized in 1840, and up to 1870, the degree conferred by the College was "Licentiate in Pharmacy." (Licentiate: One who has a license granted by a university to practice a profession; an academic degree ranking below that of doctor.)

At the end of the 1870–71 school session the degrees conferred at graduation were Licentiate in Pharmacy[a]; Master of Pharmacy upon those who evidenced professional advancement for three years after graduation; and Doctor of Pharmacy upon those who maintained the honor and dignity of the profession for ten years work after graduation.[1]

In the latter part of 1871, the College resolved to confer the degree of Graduate in Pharmacy upon graduates, instead of Licentiate of Pharmacy.[2] The Master and Doctor Degree requirements remained the same through the 1873–74 session. The Annual Circulars (catalogues) of the Maryland College of Pharmacy during the period 1875–90 do not mention the advanced degrees.

The Annual Cataglogue (1891–92) states that the professional degree conferred at graduation is that of Graduate in Pharmacy (Ph.G.). Also at this time, the following honorary degrees are described. Degree of Master in Pharmacy (M.P.) may be conferred on such graduates as have continued in the practice of pharmacy at least three years after graduating, and who shall have given evidences of advancement in the sciences of our profession, such as the Board of Trustees may deem requisite. Degree of Doctor of Pharmacy (PH.D.), this College may confer this Degree upon such graduates as may have continued in the practice of Pharmacy for at least ten years after graduation, and who, by superior scientific attainments and services rendered their profession, shall have gained an honorable reputation among their fellow-pharmacists, the medical profession, and the public in general.[3]

The practice of conferring the Honorary Degrees of Master of Pharmacy (M.P.) and Doctor of Pharmacy (PH.D. or Phar. D.) upon graduates who had "maintained the honor, diginity, etc. of the Profession:" for three and ten year periods, respectfully, was discontinued at the end of the 1894–95 session.

Up to the summer of 1894, diplomas (Licentiate or Graduate in Pharmacy had been conferred upon six graduates, and that of Doctor of Pharmacy upon fifteen persons. In 1895, far-reaching and important changes were made. The college session (for a Ph.G.), which had been of six months length since 1889, was lengthened to seven months and additional courses were added.[4]

Commencing with the session 1896–97, a "Post Graduate Course" leading to the degree of Doctor of Pharmacy (Phar.D.) was offered for the first time. Admission to this course was open to graduates in Pharmacy only, and depended upon the applicant's fitness for advanced studies, which was determined by the faculty in each individual case. The chief features of this course consisted of advanced work in the pharmaceutical, chemical and microscopical laboratories as well as a series of lectures on the different subjects pertaining to pharmacy. The instruction was almost wholly of a practical nature, and continued through-out one full session of thirty-two weeks.

The students were required to devote five whole days of every week to their work. They were expected to submit to the Faculty, two weeks before the close of the session, an original thesis, or dissertation, upon some work performed by themselves. Also, satisfactory evidence must be furnished to the Board of Trustees that the candidate for the degree of Phar. D. had, at least, four years experience at the prescription counter of some well-regulated pharmacy.

Students unable to devote the whole time required in one session to the pursuit of advanced work, were permitted to extend the course over a period of two sessions by notifying the Faculty of such intention, so that the work may be appropriately divided up. The tuitition fee for the post-graduate course was one hundred and twenty-five dollars, and the diploma fee twenty-five dollars additional.[5,6]

The annual catalogues of the College continued to list this advanced course through the session of 1899–1900. However, no graduates from this program

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[a] One of the requisites for graduation was attendance upon two full courses of lectures in a respectable college of Pharmacy, the last of which shall be in this College. The annual College session commenced October 18th and terminated February 24.

(Phar. D. Degree) were listed in the catalogues during the period 1896–1900.

From the very beginning of its career, the chief purpose of the College was to prepare its matriculants for the intelligent practice of Pharmacy as it appears in the retail drug store. In the face of much adverse criticism and confusion, with the session of 1900–01, the College supported the claim that Pharmacy is a profession by conferring a professional degree—Doctor of Pharmacy (Pharm. D.). Although some pharmacy colleges had adopted a three-year course, this College still adhered to the two-year course (Junior and Senior) both for educational and financial reasons. But the sessions were lengthened to thiry-two weeks each.[7]

To meet the wishes of students who may find it more convenient to extend their studies beyond the prescribed number of years (two), arrangements could be made to have the college course extended over three or more years.[8]

Cordell[9] stated, "In taking this step the College is believed to have exhibited its usual practical wisdom and foresight. It is mere justice to students of Pharmacy, who have spent time and money in mastering the details of scientific profession, that they should have full credit for their sacrifices and achievements, and that their degree should be equal to that granted in other corresponding professions. The example does not seem, however, to have commended itself as yet, and recently (1906) Professor Hynson[b] has urged its general adoption by colleges in a paper read before the American Pharmaceutical Association."

On May 21, 1901, this higher degree (Pharm. D.) was conferred,[c] for the first time, on the following graduates of the regular course of instruction: J. C. Barbour (Kentucky), J. J. Barnett (Alabama),[d] B. L. Cole (North Carolina), W. J. Freeman (North Carolina), S. Fox (Maryland), A. N. Hewing (Maryland), N. A. Hess (Maryland), C. H. Hudson (Maryland), J. K. Hanson (Denmark), R. E. Houston (South Carolina), E. G. Kiesling (Texas), W. W. Kidd (North Carolina), W. V. Levy (Maryland), W. F. Moody (North Carolina), L. D. Pruden (Virginia), H. C. Richardson (West Virginia), E. M. Stevens (Georgia), C. C. Thome (Pennsylvania), W. M. Wilson (North Carolina).[11]

In 1902, the College deemed it desireable to offer two graded courses of instruction, one leading to the degree of Graduate of Pharmacy, the other to the Degree of Doctor of Pharmacy. This division was made because it was believed that some students not desire to avail themselves of the more extensive and advanced pharmaceutical knowledge which the higher degree represented, but prefer to acquire so much as is necessary to fit them for the needs of the practicing pharmacist, and the requirements of the State Board of Pharmacy.[14]

Also at this time, those who previously obtained the Ph.G. Degree were permitted to enroll in the Doctor of Pharmacy program. Such candidates if successful in passing the special examinations arranged for the degree of Doctor of Pharmacy, obtained the higher degree upon payment of the required fees. On May 20, 1902, Maryland College of Pharmacy awarded twenty-five Doctor of Pharmacy degrees and nine Graduate in Pharmacy Degrees.

In the 1903–04 Annual Announcement the following is stated: "Any graduate of this College may obtain the degree of Doctor of Pharmacy upon payment of the required fee and the successful completion of those courses or parts of courses, in the present curriculum, which were not taken or were not offered during attendance at this College." On May 14, 1903, the degree of Doctor of Pharmacy was conferred upon fifteen graduates, and the degree of Graduate in Pharmacy upon nineteen.[15]

On May 13, 1904, eighteen received the Doctor of Pharmacy Degree and eleven the Graduate in Pharmacy Degree.[16]

The Maryland College of Pharmacy, on July 7, 1904, became the Department of Pharmacy of the University of Maryland (Northeast corner Lombard and Greene Streets). Beginning with the 1904–05 school year, the only degree conferred upon graduation was that of Doctor of Pharmacy.[17,18] At this time, Cordell[19] stated the degree "as being more consonant with justice and more in accordance with University usage."

In 1913, the practice of awarding a Doctor's Degree upon successful completion of the required courses, to an alumnus holding a Graduate in Pharmacy Diploma was discontinued.[20] (On May 3, 1907, the Degree of Doctor of Pharmacy was conferred upon H. A. B. Dunning,[e] Ph.G. 1897 and H. L. Whittle, Ph.G. 1893; and on June 1, 1908 upon Milton R. Walter, Ph.G. 1890).

Beginning with the School session of 1914–15 the Degree of Graduate in Pharmacy was conferred upon the completion of the two year course. This degree was a recommendation of the American Conference of Pharmaceutical Faculties, meeting held in Nashville, Tennessee, August 18, 1913. (Relative to standardization of degrees with an entrance requirement of one year's high school education).[21]

As before the union with the University, the organization of the Maryland College of Pharmacy kept up its election of officers and meetings: October 20, 1904 Pharmaceutical Hall University of Maryland Dental Building, Greene Street near Lombard; November 17, 1904 and January 19, 1905 at Tierney's Hotel, Franklin and Howard Streets; also in 1905, March 16 Belvedere Hotel on North Charles Street, July 20 Kent Island "Love Point" on the Eastern Shore, and November 16

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[b] Henry Parr Hynson, Faculty member Maryland College of Pharmacy, first President of the National Association of Retail Druggists (1898), one of the founders of the well-known Baltimore Pharmaceutical Company—Hynson, Wescott and Dunning.[10]

[c] Commencement exercises held three O'Clock Tuesday afternoon, Ford's Opera House, northside Fayette Street east of Eutaw Street.[12]

[d] Also a Graduate (Ph.G.) of the Maryland College of Pharmacy, Class of 1899.[13]

[e] One of the founders of the Pharmaceutical Company-Hynson, Wescott and Dunning.

Raleigh Hotel, Fayette and Holliday Streets; in 1906, January 18 Junker Hotel, 22 East Fayette Street, March 15 and May 17 the Eutaw House, Northwest corner Baltimore and Eutaw Streets, July 31 Cesterwood, Bear Creek (Baltimore County); and in 1907, January 18 the University Dental Building and July 19 Bay shore Park (near the present location of Fort Howard Hospital); January 16, 1908 Medical and Chirurgical Faculty Hall 847 North Eutaw Street.[22]

After a "sea-food" supper in the Casino at the Bay Shore Park (July 19, 1907 meeting), Hynson made a motion (passed) that a Committee composed of Caspari[f], Dohme[g] and Dunning confer in regard to granting the degree of Doctor of Pharmacy to members of the Maryland College of Pharmacy.[23]

At the Annual Meeting of 1908 (January 16) no report was submitted by the Committee elected to consider the feasibility of conferring the honorary Degree of Doctor of Pharmacy on those graduates of the College deemed worthy of the honor. Therefore, Hynson then presented the following resolution (seconded by William J. Lowry, Jr.): "Resolved, that the Board of Trustees be directed to confer upon all such graduates of the Maryland College of Pharmacy as graduated previous to the year 1901 and have continued to be actively engaged in Pharmaceutical pursuits, the degree of Doctor of Pharmacy at such time and place as the Board of Trustees may select, provided the Board of Trustees deem the Graduate worthy of the honor and the graduate shall pay the sum of ten dollars." After a very lengthy discussion and some changes in the original resolution, the entire subject was tabled. There being no further business the College adjourned. (This appears to be the last recorded minutes of the Maryland College of Pharmacy.)

It is interesting to note some of the objections to the granting of the Degree: the Maryland College of Pharmacy was no longer a teaching College, the wording of the resolution conveyed the impression that the Degree was to be purchased, those who did not receive the Degree would naturally resent the slight, conferring of the degree be subject to the present requirements of the Pharmacy Department University of Maryland.

The following are some of the recipients of early or honorary Doctor of Pharmacy Degrees from the Maryland College of Pharmacy or the University of Maryland. (Figure in parentheses following the name indicates the year awarded.): George W. Andrews (1869), J. Brown Baxley (1869), Charles Caspari, Jr. (1905), Charles E. Dohme (1907), Louis Dohme (1869, James P. Frames (1870), Israel J. Gratiame (1871), John F. Hancock (1907), Henry P. Hynson (1907), H. Hynson Jennings (1869), J. Faris Moore (1869), William Procter, Jr. (1871), Joseph Roberts (1870), E. Walton Russell (1869), Alpheus P. Sharp (1869), J. Jacob Smith (1869), Edward R. Squibb (1873), David Stewart (1871), William S. Thompson (1869).

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[f] Charles Caspari, Jr., Pharmacy Professor and Dean of Pharmacy Faculty University of Maryland.

[g] Probably, Charles E. Dohme a partner in the well-known Baltimore Pharmaceutical manufacturing firm Sharp and Dohme (Southwest corner Pratt and Howard Streets). Today this company is known as Merck, Sharp and Dohme.

REFERENCES

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2. Ibid., Session 1871–72, p. 10.
3. Annual Catalogue, Maryland College of Pharmacy Session 1891–92, p. 35.
4. Eugene F. Cordell, "University of Maryland," Volume-1, Lewis Publishing Company, New York-Chicago, 1907, p. 432.
5. Annual Catalogue, Maryland College of Pharmacy, Session 1895–96, p. 17.
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7. Annual Announcement, Maryland College of Pharmacy, Session 1900–01, pp. 4, 6, 7, 26.
8. Ibid., Session 1901–02, no page number.
9. Reference 4, p. 434.
10. Wedgwood Club, Baltimore, Seventy-Fifth Anniversary (1900–1975) Booklet (Edward W. Piper, Historian) p. 12.
11. Reference 8.
12. Minutes of the Maryland College of Pharmacy 1888–1908, p. 193.
13. Annual Catalogue, Maryland College of Pharmacy, Session 1899–1900, p. 27.
14. Annual Announcement, Maryland College of Pharmacy, Session 1902–03, no page number.
15. Ibid., Session 1903–04, pp. 6, 22.
16. Annual Announcement, Maryland College of Pharmacy (Department of Pharmacy of the University of Maryland) Session 1904–05, p. 20.
17. Reference 12, p. 238.
18. Reference 16, p. 6.
19. Reference 4, p. 440.
20. Annual Announcement, University of Maryland, Department of Pharmacy (Formerly the Maryland College of Pharmacy), Session 1913–14, p. 6.
21. Ibid., Session 1914–15, p. 6.
22. Reference 12, pp. 241, 243–245, 247–250, 252–254.
23. Ibid., p. 253.

calendar

Mar. 7 (Sun)—AZO Fraternity Dinner Meeting
Mar. 8–11—NARD Legislative Conference, Washington, D.C.
Mar. 14 (Sun)—Alumni Association Dinner Meeting
Mar. 28—MPhA Spring Regional Meeting, Kelly Building
April 24–29—APhA Convention, Las Vegas
June 18–20—Maryland Society Hospital Pharmacist Seminar, Williamsburg
June 20–24—MPhA CENTENNIAL CONVENTION, OCEAN CITY
Nov. 4–7—SAPHA REGIONAL CONVENTION IN BALTIMORE

BOB BERGSTEIN
JON JOHNSON

Free at last

Dog work: counting inventory, filing, keeping up-to-date price lists: that's not what we went to school for. But it takes up too many hours in a pharmacist's day. Bob Bergstein and Jon Johnson of the Clinton Pharmacy, Clinton, MD, found the answer in the IBM QS/1 System.

Jon Johnson says, "Our Medicaid volume runs in excess of $10,000 per month, and the turn-around time from submission to cashing of the check has been cut from 34 to nine days. Our Aetna payments are now paid within days against the old system which took almost two months. At 2% a month, the interest on that money alone almost justifies the cost of the machine."

Bob Bergstein concurs. "The QS/1 posts charges and third party plans automatically; prices prescriptions; prints labels — it takes only three seconds to print a refill label," Bob notes.

Call Jon Johnson or Bob Bergstein at the Clinton Pharmacy, (301) 868-2000. They'll give you a free demonstration of the QS/1 on the job. It's easy to lease. Now's the time.

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Feinberg on APhA Office of Women's Affairs

At its January 1982 meeting, the APhA Board of Trustees inaugurated the Office of Women's Affairs (OWA) with the appointment of an advisory group to spearhead this effort. Under the guidance of the advisory group, the OWA will be responsible for developing plans to implement the recommendations of APhA's Task Force on Women in Pharmacy. Stressing professional unity, the office will interact with other interested groups and individual pharmacists throughout the nation to encourage the involvement of women in association activities at the national, state, and local levels. Projects emanating from this new office will be coordinated with existing APhA services provided to members—both women and men pharmacists in different practice areas.

Members of the 1982 OWA advisory group are:

- Pharmacist Dena L. Barker, assistant dean for student affairs, Howard University College of Pharmacy and Pharmacal Sciences, Washington, DC;
- Pharmacist Madeline V. Feinberg, community practitioner, Silver Spring, MD, and clinical instructor at the University of Maryland School of Pharmacy;
- Pharmacist Charma A. Konnor, pharmacist reviewer, Food and Drug Administration—OTC Drug Evaluations, Rockville, MD, and clinical instructor at the Medical College of Virginia School of Pharmacy; and
- Pharmacist Marian R. Ricardo, director of pharmacy services, Simpson House, Philadelphia, PA.

APhA staff member Gloria N. Francke will chair the advisory group, and Vivian L. Emala will serve as staff contact for the Office of Women's Affairs.

Development of a communications mechanism and a networking system will be among the first projects that the advisory group will consider at its meeting in February 1982. Representatives of the Office of Women's Affairs will be available at the 1982 APhA Annual Meeting in Las Vegas for informal discussions related to implementation of the recommendations of the APhA Task Force on Women in Pharmacy. APhA members involved in state task forces and other organizations with program suggestions for the OWA are urged to establish liaison with APhA staff.

The *Final Report of the APhA Task Force on Women in Pharmacy* is available from the APhA Task Force on Women in Pharmacy is available from the APhA Order Desk, 2215 Constitution Avenue, NW, Washington, DC 20037 for $10.00 ($15.00 for nonmembers).

ASHP comes to Baltimore

Baltimore is the place to be on June 6-10 for ASHP's 39th Annual Meeting. This Annual Meeting combines general sessions, contributed papers, exhibits, House of Delegates' activity, and several new features. Continuing education certification will be offered for nearly all sessions.

The CE program is built around four general sessions, one of which is held each morning of the meeting. The topics selected for this year's meeting will stimulate attendees to think beyond their own practices and beyond institutional practice. "Corporate Influences in the Delivery of Health Care" is the theme for the opening general session on Monday; "Opportunities and Experiences Involving Investigational New Durgs," "Clinical Implications of the New Calcium-Channel Blocking Agents," and "Modern Management Concepts" will follow on Tuesday, Wednesday and Thursday, respectively.

ASHP's House of Delegates, the Society's major policy-making body, will convene on Monday and Wednesday afternoons. Preceding those meetings will be the Open Hearing, which provides an opportunity for all ASHP members to discuss Society policies or professional concerns with officers, Board members, and chairmen of the councils.

Information on Annual Meeting registration and accommodations is available from ASHP headquarters on request.

Specialty Board Approves Nuclear Specialty Examination

The Board of Pharmaceutical Specialties (BPS) met recently in Washington, DC, and approved the specialty certification process for nuclear pharmacists. Approval was based on recommendations made to the BPS by its Specialty Council on Nuclear Pharmacy which had been developing the certification program for over two years. The Council consists of six nuclear pharmacists appointed by the American Pharmaceutical Association's Academy of Pharmacy Practice Section on Nuclear Pharmacy and three non-nuclear pharmacists appointed by the BPS.

The certification process consists of a 4,000-hour experience requirement and a 300-question certification examination. The all-day examination will be administered on Saturday, April 24, 1982, simultaneously in Las Vegas, Nevada, and Atlanta, Georgia. Candidates interested in sitting for the examination should request an application form and additional details from BPS executive secretary Richard P. Penna, 2215 Constitution Avenue, NW, Washington, DC 20037.

Third Party Committee

Many pharmacies have seen their third party prescriptions climb to over half of their total volume, requiring a greatly increased paper-work load. Since almost all programs except Medicaid require the use of the Universal Claim Form which does not provide an identifiable space for the name of the drug, the use of National Drug Code (NDC) numbers is now routine.

The NDC number is broken into three portions. The first identifies the labeling company, and is assigned by FDA. The second and third sets are assigned by the company itself and identify the particular product, and the package size respectively. There often is an advantage to be able to tell the name of the company from the NDC number when reviewing claim forms. The accompanying list provides the NDC number for many of the companies. Often a company has been assigned more than one number to identify the division (Smith Kline French, SKF, etc.) or the place of manufacturer (Roche-USA, Roche-Puerto Rico).

National Drug Code (in numerical sequence)

Manufactures Reference Numbers

0002	LILLY
0003	SQUIB
0004	ROCHE
0005	LEDERLE
0006	MSD
0007	SKF
0008	WYETH
0009	UPJOHN
0010	PHILIPS ROXIANE INC
0011	HWD
0013	ADRIA LABS
0014	SEARLE
0015	BRISTOL LABS
0016	PHARAMACIA
0017	WAMPOLE LAB
0018	PENWALT
0019	MALLINCKRODT
0021	REED & CARNICK
0023	ALLERGAN
0024	WINTHROP
0025	SEARLE LAB
0026	DOME LAB
0027	HOLLAND-RANTOS
0028	GEIGY
0029	BEECH-MAS LABS
0031	ROBINS
0033	SYNTEX
0034	PURDUE FREDERICK
0037	WALLACE PHARM
0038	STUART ICI
0039	HOECHST PHARM
0041	COOPER
0043	DORSEY
0044	KNOLL
0045	MCNEIL
0046	AYERST
0047	WARNER CHILCOTT LAB
0048	FLINT
0049	ROERIG
0052	ORGANON
0053	ARMOUR PHARM
0056	ENDO
0057	BERON
0058	SMP
0060	ENDO INC
0062	ORTHO
0064	TEXAS PHARM
0065	ALCON
0066	DERMICK
0067	RORER
0068	MERRELL
0069	PFIZER
0070	USV LABS PR
0071	PARKE DAVIS
0072	WESTWOOD
0074	ABBOTT
0075	USV
0077	BARNES-HIND
0078	SANDOZ
0081	BW
0082	IVES
0083	CIBA
0085	SCHERING
0086	CARNRICK
0087	MEAD JOHNSON
0088	MARION LABS
0089	RINKER
0091	KREMER URBAN
0094	ARNAR STONE
0107	ORTHO PHARM PR
0108	SK & F LAB
0109	ALLERGAN CAR
0115	RICHYN
0117	CORD
0118	HOLLISTER STIER
0122	REXALL
0126	HOYT LABS
0132	FLEET
0137	J&J
0141	FULLER LABS
0142	AMFRE-GRANT
0145	STIEFEL
0149	NORWICH-EATON
0161	CUTTER LABS
0163	ELDER
0169	FOUGERA
0172	ZENITH
0182	GENERIX DRUG
0183	DOW PHARM
0185	VITARINE
0186	ASTRA
0187	ICN PHARM
0193	AMES CO
0196	RACHELLE
0205	LEDERLE PARENTE
0206	LEDERLE METHOTR
0221	DOONER
0228	PUREPAC PHARM
0234	SCHMID
0242	STANLABS PHARM
0245	UPSHER SMITH
0256	FLEMING
0258	INWOOD LABS
0318	PANRAY
0331	PREMO
0332	BIOCRAFT
0339	BAXTER LABS
0345	FEDERAL PHARM
0349	PARMED
0364	SCHEIN
0369	KEY PHARM
0378	MYLAN
0386	GEBAUER
0395	HUMCO
0451	MURO
0456	O'NEAL, JONES, FELD.
0470	WARNER-CHILCOTT LAB
0472	BARRE
0477	OBETROL
0484	SK&F CO
0517	AMER QUININE
0524	RUCKER
0527	LANNETT
0536	RUGBY
0537	SPENCER-MEAD
0570	NAT PHARM MFG
0574	CANFIELD
0585	FISONS
0591	DANBURY
0615	VANGUARD
0662	ROERIG/PFIZER
0663	PFIZER PHARM
0668	VICOBIN
0677	UNITED RESEARCH
0689	DAN PHARM
0719	BIOLINE
0725	BOLAR
0740	WARNER-CHLCT PHARM
0771	REYMAN
0777	DISTA
0779	COOPER DRUG
0839	MOORE DRUG EXCH
0849	INGRAM
0893	BARRY MARTIN
0927	PREIFER
0928	WOLINS PHARM
0936	ROSS LABS
0951	FLINT LABS CAN
0971	WINTHROP PROD
0991	ALCON (PR)
0994	DELBAY PHARM
0995	PEIPHARMECS
8880	SHERWOOD MED
10337	DOAK PHARMACAL
10337	DRAKE PHARM
11014	SCHERER
11034	SHERWOOD LAB
11414	WILEN DRUG
11463	BARRY LABS
11489	BOOTS DRUG
12154	ALLISON LABS
12280	BAY LABS
12416	DOYLES PHARM
12770	MORTON PHARM
18329	BIALEKS
18393	SYNTEX LABS PR
19487	ARNELL LABS
33751	MODERN DRUGS
36358	STANLABS
37000	PROCTER & GAMBLE
38242	ADRIA LABS
43567	MD PHARM
45124	DRUMMER LABS
46193	CHELSA
49073	MDV PHARM
49334	PHARMADYNE
50187	AYERST INTL INC.

You really have a lot to offer...

The most complete line of insulins
Your insulin patients vary greatly in their specific requirements for insulin. Not only is *daily dosage* a factor in achieving satisfactory control, but duration of insulin action is also. The Lilly line of insulin products is so complete that it can meet the needs of virtually all insulin-dependent diabetics.

For most diabetics . . . Iletin I
All Lilly insulin preparations bearing the trademark Iletin I contain a mixture of beef and pork insulin. The majority of diabetics manage their diabetes most effectively by using one or more of the many forms of Lilly insulin that are currently available. In 1980, Lilly improved the purity of its insulin products significantly, so that all forms now contain less than 50 parts per million of proinsulin (proinsulin content is the standard measure of insulin purity). The "single-peak" Iletin sold between 1972 and 1980 had a proinsulin content of <3000 parts per million.

For diabetics with special needs . . . Iletin II
Iletin II products are insulins derived from only one animal source—either beef or pork. The use of Iletin II, Pork, or Iletin II, Beef, is generally reserved for patients who demonstrate a clinical need for single-species insulin. Iletin II products are in a new class, recognized as purified insulins. All purified insulins contain <10 parts per million of proinsulin.

ILETIN® I
beef-pork insulin

Lilly
100682

ILETIN® II
purified pork insulin
purified beef insulin

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insulins that maximize control

Additional information available to the profession on request.

IF I HAD MY LIFE TO LIVE OVER

I'd dare to make more mistakes next time.
I'd relax, I would limber up.
I would be sillier than I have been this trip.
I would take fewer things seriously.
I would take more chances.
I would climb more mountains and swim more rivers.
I would eat more ice cream and less beans.
I would perhaps have more actual troubles, but I'd have fewer imaginary ones.

You see, I'm one of those people who live sensibly and sanely hour after hour, day after day.
Oh, I've had my moments, and if I had it to do over again, I'd have more of them.
Just moments, one after another, instead of living so many years ahead of each day.
I've been one of those persons who never goes anywhere without a thermometer,
a hot water bottle, a raincoat and a parachute.
If I had to do it again, I would travel lighter than I have.

If I had my life to live over, I would start barefoot earlier in the spring
and stay that way later in the fall.

I would go to more dances.
I would pick more daisies.

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LETTERS

Dear Mr. Banta:

We are pleased to announce the availability of two revised joint statements of the American Thoracic Society and Centers for Disease Control, *Diagnostic Standards and Classification of Tuberculosis and Other Mycobacterial Diseases* and *The Tuberculin Skin Test.* Copies are enclosed for your review. We would appreciate your announcing the availability of these statements in the next edition of the *Maryland Pharmacist.* Free copies are available by contacting our Association at the telephone number noted below.

Although tuberculosis is a curable and preventable disease, it continues to be transmitted. In 1980, tuberculosis in Maryland remained above the national average with 610 cases reported, representing a case rate of 14.5 per 100,000 population. The Centers for Disease Control ranked Maryland 13th and Baltimore City 5th as compared to other State and city case rates. Nationally, the year 1980 was the first time since 1963 that there has been an actual increase in the number of new cases of tuberculosis. Tuberculosis is the third leading reportable infectious disease and the second leading cause of infectious disease deaths in the United States. As a result of President Reagan's recent budget cuts, federal funding for local tuberculosis control programs has been eliminated. We believe that a national commitment is mandatory if we are to reduce the continuing transmission of tuberculosis.

Sincerely,
Gina Westfall
Director
Adult Lung Disease Programs
American Lung Association
(301) 685-6484

Dear Dave:

In an effort to control the theft and forgery of Franklin Square Hospital prescription blanks, we have revised both the form and their procedure for use. Effective December 1, 1981, the white Franklin Square Hospital prescription blanks have been replaced with two new blanks, a green prescription blank marked "Controlled Substances" and a white blank bearing the statement "Not Valid For Schedule II Substances". At present, only Schedule II drugs are *required* to be written on the controlled substance blank. Schedules III, IV, and V may still be written on the white blanks. Both forms are serially numbered and their distribution within the hospital recorded by the pharmacy.

Please be aware that during the phase in period, there may still be patients with prescriptions written on the old forms. We request that community pharmacists exercise professional judgement during the phase in period.

If you have any questions concerning the validity of a prescription, please call the pharmacy at 391-3900, extension 5381 for assistance.

Sincerely,
Roger G. Heer, R.Ph.
Director of Pharmacy

Dear Mr. Banta:

In response to your letter request, I have described below recent changes in Glenbrook products. Methapyrilene fumarate has been removed from Cope after it was found to be a possible carcinogen. None of our products contain tartrazine (Yellow Dye #6). Bayer Aspirin is now available with a thin coating which eliminates all aspirin aftertaste and prevents tablets from flaking during storage without interfering with aspirin's bioavailability. Two Diaparene baby products have had a name switch corresponding to the product's consistency. Diaparene Ointment is now called Diaparene Medicated Creme and Diaparene Peri-Anal Creme is now called Diaparene Peri-Anal Ointment. I do not anticipate any other product changes in the near future.

The following products are no longer manufactured by Glenbrook Laboratories:

Bayer Acetaminophen Non-Aspirin Pain Reliever
Bayer Decongestant Cold Tablets
Breacol *Metholated* (Breacol Regular still available)
Dr. Lyon's Tooth Powder
Fizrin
Jayne's P.W. Vermifuge
Phillips' Toothpaste
Phillips' Milk of Magnesia, Chocolate Flavored (Regular and Mint Flavored Phillips' Milk of Magnesia is still available).
ZBT

The general policy at Glenbrook Laboratories regarding "flagging" of product changes is to flag major product changes and not to flag minor product changes.

If you need additional product information, please contact me.

Sincerely,
Katherine Farragher
Research Assistant

Announcing the Reactivation of the

EMPLOYEE—EMPLOYER RELATIONS FORUM

The purpose of the Forum is to deal creatively with the issues in Maryland Pharmacy employer and employee relations. This Committee of the Association is made up of individuals from a wide variety of practice settings. We are asking for input on current employment issues from all segments of the profession. The Forum will act as a "sounding board" on these issues and will provide some ombudsman activity.

We are asking for your help in submitting issues to the Forum for comment and response. If you have a suggestion, idea, or comment, contact the Employer/Employee Relations Forum at: 650 W. Lombard St., Baltimore, Md. 21201.

The reactivation of the Employer—Employee Relations Forum coincides with the Association's Centennial. The Committee decided that there are many favorable sentiments about the profession of pharmacy and what it means to members that are often left unspoken. During the Centennial year members are asked to express in a positive way what pharmacy means to them. Here is one such sentiment:

The 100th anniversary of the Maryland Pharmaceutical Association and the 25th anniversary of my licensure as a pharmacist seemed an appropriate time to comment on the state of the profession.

1. Pharmacists are overtrained and/or underutilized.
2. Courses being taught are irrelevant to our needs.
3. Physicians will not listen to my advice, even if I choose to give it.
4. Chain pharmacies make it impossible for the independent to survive.
5. Fees for welfare prescriptions are too low.

All these were said during the 1950's.

There is no doubt an element of truth to each of those statements now as there was then. There must always be pharmacists who are "overtrained" to take advantage of opportunities to grow professionally.

How is relevance determined? Although most graduates choose hospital or community practice, students are prepared for numerous other areas of endeavor. What is relevant to one area could be well be totally unnecessary in another. No one in 1957 could say for sure what would be relative for 1982. Similarly, no one today can be certain what will be relative for the year 2007.

That physicians will not listen to pharmacists is an alibi many of us use to excuse our own inaction.

Independent pharmacies are still around, even though not in the numbers as before. In fact, chains may have done the independents a favor by compelling them to become both efficient and effective. The marginal practitioners, those who can't or won't change are no doubt being eliminated. There are limits to the number of no-service, low price patrons. There is a market awaiting the service oriented practitioner.

For the individual with the desire to take the initiative in the home health care field, there are at least as many opportunities as 25 years ago. There are opportunities in the traditional roles as hospital or community practitioners as well as related and new areas. There are clinical roles for the pharmacist in hospitals, and nursing homes as well as other institutions. The more innovative among us will develop and expand the clinical role of the community pharmacist.

In 25 years, only the name has changed; now it's Medicaid fees that are too low.

I suspect that 100 years from now, someone will be writing these same things. The opportunities have always been and will always be there for those with the forethought to set goals, a conviction in the value of their goals and a willingness to expend the effort to attain them.

The more the change, the more things stay the same.

Marvin L. Oed, Pharm. B.S., P.D.
Clinical Assistant Professor
Department of Pharmacy Practice
and Associate Director
Professional Experience Program

When was the last time your insurance agent gave you a check . . . that you didn't ask for?

MAYER and STEINBERG INSURANCE AGENCY GIVES A DIVIDEND CHECK TO ANTHONY G. PADUSSIS EVERY YEAR! Usually for more than 20% of his premium.

TONY is one of the many Maryland pharmacists participating in the Mayer and Steinberg/MPhA Workmen's Compensation Program—underwritten by American Druggists Insurance Company.

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Your American Druggists' Insurance Co. Representative

ARMCO AMERICAN DRUGGISTS' INSURANCE

M AND S

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484-7000

Please contact me. I am interested in receiving more information about the Mayer and Steinberg/MPhA Workmen's Compensation Program. ☐ Call ☐ Write.

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firm
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A well-stocked TROJANS® display rack can really pack a profit into a few feet of counter space. Because more TROJANS are sold to consumers in drugstores than all other brands combined…this delivers $2.30 for every dollar you invest (ROI).

Today the condom market has reached an all time high in sales. More and more people are rediscovering the condom as they search for a safe, effective method of contraception without side effects.

TROJANS are backed by a big national advertising program that helps you have a faster turnover. No wonder TROJAN brand condoms are recommended by more pharmacists than all other brands put together.

Ask your TROJAN territory manager for complete display information or write us to find out how to get your share of this most profitable line.

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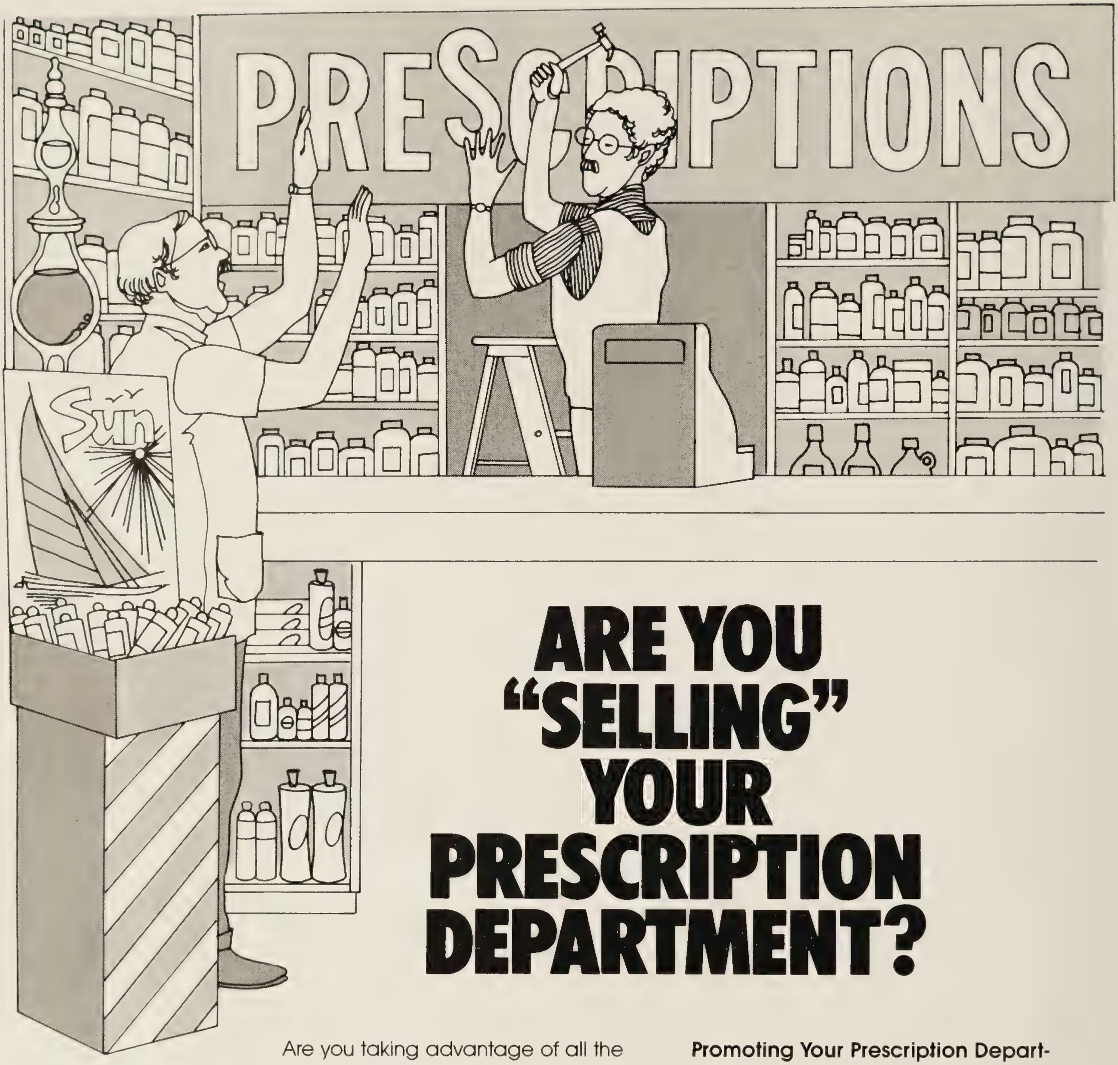
While no contraceptive provides 100% protection, TROJAN brand condoms, when properly used, effectively aid in the prevention of pregnancy and venereal disease.



ARE YOU "SELLING" YOUR PRESCRIPTION DEPARTMENT?

Are you taking advantage of all the proven methods to promote a pharmacy's prescription department?

If not, SK&F's newest 30-minute videotape program can start you thinking about the opportunities you may be missing.

Our new management program is called **Promoting Your Prescription Department**—and it's designed as a seminar for interested groups of community pharmacists.

You can learn more about advertising, promotional budgets, personal selling, publicity, pharmacy layout, and evaluation of your promotion efforts.

Promoting Your Prescription Department is one more valuable addition to the pharmacy management series now available from SK&F.

Ask your SK&F Representative how you can obtain this videotape program for your next meeting.

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Pharmacy
Support

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Smith Kline &French Laboratories
Philadelphia, Pa

Manufacturer disclosure [redacted]

To keep drug product selection a workable concept, pharmacists need information about the source of drug products before they purchase them.

The California Pharmacists Association wrote to drug manufacturers and distributors, asking them to provide new and updated information on which companies actually manufacture the final dosage form. On these pages is the latest information provided to the association.

We have added some drugs to the list because they are now available from a greater number of sources. All information concerning the manufacturers of drug products applies only to those dosage forms and strengths distributed by the companies. The distributor appears on the left, the manufacturer on the right.

Continued from February

Towne, Paulsen & Co.	Barr Labs
Vangard Labs*	M.D. Pharm.
Wallace Labs	Carter-Wallace
West-Ward*	Halsey Drug Co.
Wolins Pharmacal*	M.D. Pharm. or Generic Pharm.

Doxycycline Hyclate[2] 50 mg caps

Geneva Generics	Rachelle Labs (100 mg)
Ladco Labs	Rugby Labs[1] or Rachelle Labs
Parmed Pharm.	Rachelle Labs
Pfizer Pharm.	Pfizer Pharm.
Rugby Labs	Rachelle Labs
Vangard Labs*	Rachelle Labs
West-Ward*	Danbury Pharmacal
Wolins Pharmacal*	Rachelle Labs

Erythromycin Base 250 and 500 mg tabs

Abbott Labs	Abbott Labs
Dista Products Co.	Eli Lilly & Co.
A.H. Robins	A.H. Robins
The Upjohn Co.	The Upjohn Co.

Erythromycin Stearate 250 and 500 mg tabs

Abbott Labs	Abbott Labs
H.R. Cenci Labs	Zenith Labs
Coast Labs	Mylan Pharm.
Geneva Generics	Mylan Pharm. or Zenith Labs
ICN Pharm.*	Barre Drug Co.
Ladco Labs	Rugby Labs[1] or Mylan Pharm.
Lederle Labs	Barr Labs or Mylan Pharm.
McKesson Labs*	Barr Labs (250 mg) Mylan Pharm. (500 mg)
Parke-Davis	Parke-Davis
Parmed Pharm.	Barr Labs, Zenith Labs, Mylan Pharm. or Richie
Penta Products	Barr Labs
Pfipharmecs	Pfizer Pharm.
Purepac	Purepac
Rexall Drug Co.	Mylan Pharm.
Rugby Labs	Mylan Pharm. or Chelsea Labs
Smith Kline & French	Mylan Pharm.
E.R. Squibb & Sons	E.R. Squibb & Sons
Towne, Paulsen & Co.	Mylan Pharm.
Vangard Labs*	Mylan Pharm.
West-Ward*	Zenith Labs
Wolins Pharmacal*	Zenith Labs or Barr Labs (250 mg) Mylan Pharm.
Wyeth Labs	Mylan Pharm.

Ferrous Gluconate 300 or 325 mg tabs

H.R. Cenci Labs	Cord Labs or Richlyn Labs
Coast Labs	Phoenix Labs or Tablicaps
Geneva Generics	Cord Labs or Tablicaps
Invenex Pharm.*	Invenex Pharm.
Lederle Labs	KV Pharm.
Parmed Pharm.	Bolar Pharm. or Richlyn Labs
Penta Products	Tablicaps
Rugby Labs	Chelsea Labs
Vangard Labs*	Richlyn Labs
West-Ward*	Richlyn Labs
Wolins Pharmacal*	Tablicaps or Richlyn Labs

Ferrous Sulfate 300 and 325 mg tabs

H.R. Cenci Labs	Richlyn Labs or Tablicaps
Coast Labs	Phoenix Labs or West Coast Labs
Geneva Generics	Cord Labs or Tablicaps
Invenex Pharm.*	Invenex Pharm.
ICN Pharm.*	ICN Pharm.
Lederle Labs	KV Pharm.
Eli Lilly & Co.	Eli Lilly & Co.
Parke-Davis	Parke-Davis
Parmed Pharm.	Richlyn Labs or Standard Labs
Penta Products	Richlyn Labs
Philips Roxane	Philips Roxane
Purepac	Purepac
Rugby Labs	Chelsea Labs
Stayner Corp.	W.T. Thompson or Chase Chemical
Towne, Paulsen & Co.	Towne, Paulsen & Co.
Vangard Labs*	Drummer Labs
West-Ward*	Standard Pharm.
Wolins Pharmacal*	Tablicaps or Richlyn Labs

Fluocinolone Acetonide 0.025% and 0.01% cream

Allergan Pharm.	Marion Labs
Parmed Pharm.	Thames Pharm.
Rugby Labs	Clay Park Labs
Syntex Labs*	Syntex Labs

Glutethimide 0.125, 0.25, and 0.5 gm tabs

H.R. Cenci Labs	Zenith Labs
Coast Labs	M.D. Pharm.
Geneva Generics	Cord Labs
Ladco Labs	Rugby Labs[1] or Chelsea Labs
McKesson Labs*	Cord Labs
Parmed Pharm.	Cord Labs
Purepac	Cord Labs
Rugby Labs	Chelsea Labs
Stayner Corp.	Cord Labs
Vangard Labs*	M.D. Pharm.
Wolins Pharmacal*	M.D. Pharm., Lannet Co. or Danbury Pharmacal

Hydralazine HCl 25 and 50 mg tabs

Barr Labs	Barr Labs
H.R. Cenci Labs	Zenith Labs or Par Pharm.
Ciba Pharm.	Ciba-Geigy
Geneva Generics	Cord Labs or Zenith Labs
Lederle Labs	Lederle Labs
Lemmon	Lemmon
McKesson Labs*	Barr Labs
Parmed Pharm.	Premo Pharm., Zenith Labs or Cord Labs

Penta Products	Barr Labs
Purepac	Barr Labs (25 mg) and Cord Labs (50 mg)
Rexall Drug Co.	Barr Labs
Stayner Corp.	Cord Labs
Towne, Paulsen & Co.	Barr Labs
Vangard Labs*	Barr Labs
West-Ward*	Danbury Pharmacal (25 mg) Richlyn Labs (50 mg)
Whiteworth	Cord Labs
Wolins Pharmacal*	Danbury Pharmacal, Barr Labs, Zenith Labs or Premo Pharm.

Hydrochlorothiazide 50 mg tabs

Abbott Labs	Abbott Labs
Barr Labs	Barr Labs
H.R. Cenci Labs	Camall Co.
Ciba Pharm.	Ciba-Geigy
Coast Labs	Camall Co.
Geneva Generics	Cord Labs
Ladco Labs	Rugby Labs[1] or Chelsea Labs
Lederle Labs	Barr Labs or Lederle Labs
Lemmon	Reid-Provident Labs
McKesson Labs*	Inwood Labs
Merck Sharp & Dohme	Merck Sharp & Dohme
Parke-Davis	Abbott Labs
Parmed Pharm.	Zenith Labs, Bolar Pharm., Heather Drug Co. or Premo
Penta Products	Barr Labs
Philips Roxane	Philips Roxane
Purepac	Bolar Pharm. or Cord Labs
Rexall Drug Co.	Camall Co.
Rugby Labs	Chelsea Labs
Smith Kline & French	Philips Roxane
Stayner Corp.	Generic Pharm.
E.R. Squibb & Sons	Mylan Pharm.
Towne, Paulsen & Co.	Towne, Paulsen & Co.
Vangard Labs*	Generic Pharm.
West-Ward*	West-Ward
Whiteworth	Zenith Labs
Wolins Pharmacal*	Zenith Labs, Generic Pharm., Chromalloy Pharm. or Camall Co.

Hydrochlorothiazide, Reserpine, Hydralazine tabs

H.R. Cenci Labs	Camall Co. or Bolar Pharm.
Ciba	Ciba-Geigy
Coast Labs	Bolar Labs
Geneva Generics	Zenith Labs
Lederle Labs	Danbury Pharmacal
Parmed Pharm.	Camall Co. or Zenith Labs
Penta Products	Danbury Pharmacal
Purepac	Bolar Pharm.
Rugby Labs	Chelsea Labs
Stayner Corp.	Danbury Pharmacal
Towne, Paulsen & Co.	Bolar Pharm.

Hydrocortisone ¼%, ½% and 1% cream or ointment

Barnes-Hind Pharm.	Barnes-Hind Pharm.
Burroughs Wellcome Co.	Burroughs Wellcome Co.
H.R. Cenci Labs	H.R. Cenci Labs
Coast Labs	Chemrich Pharm.
Dermik Labs	Dermik Labs
Drummer Labs	Lemmon
E. Fougera & Co.	Byk-Golden
Geneva Generics	Ambix Labs
Ladco Labs	Rugby Labs[1]
Lemmon	Lemmon
Life Labs	Life Labs
Miles Pharm.	Miles Pharm.
Owen Labs*	Owen Labs
Parke-Davis	Parke-Davis
Pfeiffer	Lemmon
Parmed Pharm.	Ambix Labs, Pharma Derm or Clay Park Labs
Penta Products	Life Labs or Pharma Derm
Pfipharmecs	Pfizer Pharm.
Purepac	Purepac
Rowell Labs	Rowell Labs
Rugby Labs	Clay Park Labs
Stayner Corp.	Ambix Labs
Towne, Paulsen & Co.	Towne, Paulsen & Co.
The Upjohn Co.	The Upjohn Co.
Vangard Labs*	Schaeffer-Davis
West-Ward*	Biocraft Labs
Wolins Pharmacal*	Schaeffer-Davis or Ambix Labs

Imipramine 10, 25 and 50 mg tabs

Abbott Labs	Abbott Labs
H.R. Cenci Labs	Bolar Pharm.
Coast Labs	Cord Labs
Geigy Pharm.	Ciba-Geigy
Geneva Generics	Cord Labs
Ladco Labs	Rugby Labs[1] or Chelsea Labs
Lederle Labs	Biocraft Labs
McKesson Labs*	Biocraft Labs
Parmed Pharm.	Premo Pharm. or Bolar Pharm.
Penta Products	Biocraft Labs
Philips Roxane	Philips Roxane
Purepac	Bolar Pharm.
A.H. Robins	Biocraft Labs
Rugby Labs	Chelsea Labs
Smith Kline & French	Smith Kline & French
Stayner Corp.	Cord Labs or Philips Roxane
Towne, Paulsen & Co.	Biocraft Labs
Vangard Labs*	Bolar Pharm.
West-Ward*	Biocraft Labs
Wolins Pharmacal*	Biocraft Labs

Isoniazid 100 mg tabs

Barr Labs	Barr Labs
H.R. Cenci Labs	Zenith Labs or Richlyn Labs
Geneva Generics	Zenith Labs (100 mg) or Bolar Pharm. (300 mg)
Eli Lilly & Co.	Eli Lilly & Co.
McKesson Labs*	Danbury Pharmacal
Merrell Dow Pharm.	Merrell Dow Pharm.
Parmed Pharm.	Zenith Labs or Bolar Pharm.
Penta Products	Barr Labs
Purepac	Purepac
Rugby Labs	Chelsea Labs
E.R. Squibb & Sons	E.R. Squibb & Sons
Stayner Corp.	Barr Labs
Towne, Paulsen & Co.	Towne, Paulsen & Co.
Vangard Labs*	Danbury Pharmacal
West-Ward*	West-Ward
Wolins Pharmacal*	Ormont or Bolar Pharm.

Isosorbide Dinitrate 5, 10, 20, 30 & 40 mg tabs or caps sublingual and/or oral

Barr Labs	Barr Labs
H.R. Cenci Labs	Bolar Pharm. or Par Pharm.
Coast Labs	Bolar Pharm.
Ives Labs*	Ives Labs
Geneva Generics	Cord Labs
Ladco Labs	Rugby Labs[1] or Chelsea Labs
Lederle Labs	Cord Labs
McKesson Labs*	Danbury Pharmacal
Parmed Pharm.	Bolar Pharm., Zenith Labs, Barr Labs or Par Pharm.
Penta Products	Barr Labs
Purepac	Purepac, Bolar Pharm. or Cord Labs
Rugby Labs	Chelsea Labs
Stayner Corp.	Barr Labs or Cord Labs (40 mg)
Towne, Paulsen & Co.	Cord Labs

** No response was received from this company. The information listed has been taken from previous articles.*

[1] See the Rugby listing to determine the manufacturer of this product.

Vangard Labs*	Zenith Labs
West-Ward*	West-Ward
Wolins Pharmacal*	Zenith Labs, Danbury Pharmacal or Barr Labs

Lithium Carbonate tabs or caps

Miles Pharm.	Pfizer Pharm.
Penta Products	Philips Roxane
Pfipharmecs	Pfizer Pharm.
Philips Roxane	Philips Roxane
Rowell Labs	Rowell Labs
Stayner Corp.	Philips Roxane

Meclizine HCl 12.5 and 25 mg tabs

H.R. Cenci Labs	Par Pharm. or Cord Labs
Coast Labs	Cord Labs or Camall Co.
Geneva Generics	Cord Labs
Ladco Labs	Rugby Labs[1] or Chelsea Labs
Lederle Labs	Cord Labs
McKesson Labs*	Richlyn Labs
Parmed Pharm.	Bolar Pharm., Zenith Labs or Par Pharm.
Penta Products	Par Pharm.
Purepac	Cord Labs or Camall Co.
Rugby Labs	Chelsea Labs
Stayner Corp.	Camall Co.
Towne, Paulsen & Co.	Generic Pharm. or Danbury Pharmacal
Vangard Labs*	Camall Co.
West-Ward*	West-Ward
Wolins Pharmacal*	Camall Co., Zenith Labs or Generic Pharm.

Meprobamate 200 and 400 mg tabs

Barr Labs	Barr Labs
H.R. Cenci Labs	Zenith Labs or Cord Labs
Coast Labs	Cord Labs
Drummer Labs	Lemmon
Geneva Generics	Cord Labs
ICN Pharm.*	ICN Pharm.
Ladco Labs	Rugby Labs[1] or Chelsea Labs
Lederle Labs	Barr Labs or Lederle Labs
Lemmon	Lemmon
McKesson Labs*	McKesson Labs
Parke-Davis	Parke-Davis
Parmed Pharm.	Barr Labs, Richlyn Labs, Zenith Labs or Cord Labs
Penta Products	Barr Labs
Philips Roxane	Philips Roxane
Purepac	Purepac
Rexall Drug Co.	Towne, Paulsen & Co.
Rugby Labs	Chelsea Labs
Smith Kline & French	Smith Kline & French
Stayner Corp.	Barr Labs
Towne, Paulsen & Co.	Towne, Paulsen & Co.
Vangard Labs*	Generic Pharm.
Wallace Labs	Carter-Wallace
West-Ward*	West-Ward
Wolins Pharmacal*	Blue Cross Products, Zenith Labs, Generic Pharm. or Danbury Pharmacal
Wyeth Labs	Wyeth Labs

Methenamine Mandelate 0.5 and 1 gm tabs

H.R. Cenci Labs	Tablicaps
Coast Labs	Cord Labs or Tablicaps
Geneva Generics	Cord Labs
Invenex Pharm.*	Invenex Pharm.
Ladco Labs	Rugby Labs[1] or Heather Drug Co.
McKesson Labs*	Cord Labs
Parke-Davis	Parke-Davis
Parmed Pharm.	Heather Drug Co.
Penta Products	Tablicaps
Rugby Labs	Tablicaps
Stayner Corp.	Chromalloy Pharm.
Vangard Labs*	Heather Drug Co.
West-Ward*	Standard Pharm.
Wolins Pharmacal*	Heather Drug Co. or Tablicaps

Nicotinic Acid 50 and 100 mg tabs

Abbott Labs	Abbott Labs
H.R. Cenci Labs	West Coast Labs
Coast Labs	West Coast Labs
ICN Pharm.*	ICN Pharm.
Eli Lilly & Co.	Eli Lilly & Co.
McKesson Labs*	McKesson Labs
Parke-Davis	Parke-Davis
Philips Roxane	Philips Roxane
Rugby Labs	Chelsea Labs
Smith Kline & French	Philips Roxane
E.R. Squibb & Sons	E.R. Squibb & Sons
Stayner Corp.	Stayner Corp.
Towne, Paulsen & Co.	Towne, Paulsen & Co.
Vangard Labs*	Generic Pharm.
West-Ward*	West-Ward
Wolins Pharmacal*	Generic Pharm.

Nitrofurantoin 50 and 100 mg tabs or caps

H.R. Cenci Labs	Bolar Pharm.
Geneva Generics	Bolar Pharm. or Zenith Labs
Ladco Labs	Rugby Labs[1]
McKesson Labs*	Pierrel America
Norwich-Eaton	Eaton Labs, Inc.
Parmed Pharm.	Bolar Pharm.
Penta Products	Bolar Pharm.
Purepac	Ketchum Labs or Bolar Pharm.
Rugby Labs	Chelsea Labs
Stayner Corp.	Bolar Pharm.
Towne, Paulsen & Co.	Ketchum Labs
Vangard Labs*	Ketchum Labs (tabs) Bolar Pharm. (caps)
West-Ward*	Ketchum Labs
Wolins Pharmacal*	Bolar Pharm. or Zenith Labs

Nystatin oral tabs, suspension and vaginal tabs

Parmed Pharm.	Premo Pharm.
Rugby Labs	Chelsea Labs
E.R. Squibb & Sons	E.R. Squibb & Sons
Wolins Pharmacal*	Premo Pharm.

Papaverine HCl 150 mg caps

H.R. Cenci Labs	Generic Pharm.
Central Pharm.	Central Pharm.
Coast Labs	Cord Labs or Phoenix Labs
Geneva Generics	Cord Labs
ICN Pharm.*	ICN Pharm.
Ladco Labs	Rugby Labs[1] or Chelsea Labs
Lederle Labs	Mylan Pharm.
Lemmon	Danbury Pharmacal
Marion Labs	Marion Labs
McKesson Labs*	Cord Labs
Parke-Davis	Marion Labs
Parmed Pharm.	Inwood Labs, Heather Drug Co. Zenith Labs or Premo Pharm.
Penta Products	Generics
Philips Roxane	Cord Labs
Purepac	Purepac
Rugby Labs	Chelsea Labs
Stayner Corp.	Cord Labs
Towne, Paulsen & Co.	Mylan Pharm. or Cord Labs
Vangard Labs*	Danbury Pharmacal
West-Ward*	Danbury Pharmacal
Wolins Pharmacal*	Chromalloy Pharm. or Zenith Labs

Continued in April

** No response was received from this company. The information listed has been taken from previous articles.*

[1] See the Rugby listing to determine the manufacturer of this product.

ABSTRACTS

Excerpted from PHARMACEUTICAL TRENDS, published by the St. Louis College of Pharmacy; Byron A. Barnes, Ph.D., Editor and Leonard L. Naeger, Ph.D., Associate Editor

AMINOGLUTETHIMIDE:

Twenty years ago aminoglutethimide was utilized as an anticonvulsant. It was withdrawn from the market because it caused adrenal insufficiency and hypothyroidism. The drug blocks the conversion of cholesterol to steroidal products normally synthesized by the adrenal gland. Because of this activity, it was used in patients with excessive adrenal activity, e.g. Cushings disease. It is very effective especially when combined with radiation therapy. *Med Lett Drugs Ther,* Vol. 23, #16, p. 71, 1981.

HEROIN:

Cancer patients were given injections of either morphine or heroin to control pain. After a period of time, each patient received the other analgesic in a cross-over fashion. Although heroin was more potent than morphine, at equianalgesic doses there was no difference in their effectiveness or toxicity. *N ENG J MED,* Vol. 304, #25, p. 1501, 1981.

SALICYLATE ABSORPTION:

A commonly used over-the-counter antidiarrheal preparation, Pepto-Bismol, contains bismuth subsalicylate as an active ingredient. When ingested on an empty stomach, salicylate levels capable of producing toxicity can be found in the plasma. It is suggested that patients using this preparation chronically be advised to watch for possible development of signs of salicylate intoxication. *CLIN PHARM,* Vol. 29, #6, p. 788, 1981.

BENDECTIN:

For many years, people have studied the association between the anti-nauseant drug Bendectin and birth defects. Until 1976, Bendectin contained doxylamine succinate, dicyclomine hydrochloride and pyridoxine hydrochloride. Dicyclomine was removed from the formulation after that date and in 1978 approximately 3 million prescriptions were written for the drug. Information gathered between 1968 and 1978 was evaluated and the authors of this paper have failed to find a correlation between the product and birth defects. As is the case with all drugs used during pregnancy, the potential value of the agent used should be weighed against the possible adverse reactions before it is prescribed. *J AM MED A* Vol. 245, #22, p. 2311, 1981.

PROPRANOLOL-CIMETIDINE INTERACTION:

Propranolol (Inderal) was administered to patients and blood levels were determined. Cimetidine (Tagamet) was then added to the regimen and it was noted that the plasma levels of the beta-adrenergic blocking agent were significantly elevated. It is concluded that cimetidine reduces the first-pass hepatic extraction of propranolol and thus allows for more of the drug to gain access to the blood stream as the active compound. *BR MED J,* Vol. 282, #6280, p. 1917, 1981.

BENZODIAZEPINE ANTAGONIST:

A new drug has been synthesized which has the ability to reverse the effects produced by the benzodiazepine derivatives, e.g. diazepam (Valium), chlordiazepoxide (Librium). The new agent is thought to be valuable in reversing signs of toxicity produced by these depressants and may also be useful in helping to determine the mechanism of action of such agents. Currently it is thought that benzodiazepine derivatives act on a specific receptor which in turn results in facilitation of the inhibitory effects produced by gamma amino butyric acid. *LANCET,* Vol. II, #8236, p. 8, 1981.

QUINIDINE-RIFAMPIN INTERACTION:

Plasma levels of quinidine were monitored in patients receiving rifampin and in a control population group. Since rifampin, an anti-tubercular agent, has been identified as a potent hepatic microsomal enzyme inducer, it was not surprising to find that the plasma levels of the antiarrhythmic agent were significantly lower when rifampin was added to the regimen. *N ENG J MED,* Vol. 304, #24, p. 1466, 1981.

TOLUIDINE BLUE:

A new method of detecting squamous carcinoma of the oral cavity has been devised using toluidine blue dye. The substance is used as a mouth rinse and selectively stains the abnormal tissue. The diagnostic technique can detect problems which might not be seen during a routine oral examination. *J AM MED A,* Vol. 245, #23, p. 2408, 1981.

ANTIBIOTIC-ASSOCIATED COLITIS:

Clostridium difficili and its toxin were first associated with antibiotic-induced colitis in 1978. Since that time various treatments have been utilized, but vancomycin, given orally in doses of 125 mg every 6 hours for 5 days, seems to best control the organism. Elderly patients are more susceptible to the infection. Approximately 80% of the reports of this type of colitis implicate clindamycin and lincomycin, but it was also seen in patients who have received ampicillin, tetracycline, chloramphenicol, cephalosporins, penicillins, cotrimoxazole, and metronidazole. *BR MED J,* Vol. 282, #6280, p. 1913, 1981.

DOXPICOMINE:

A new analgesic was compared with morphine in postoperative patients. The drug, doxpicomine, was as effective as morphine in relieving this type of pain. The drug is chemically different from the opiates, but seems to work in a manner identical to them. The drug may not be as likely to cause physical addiction as morphine. *CLIN PHARM,* Vol. 29, #6, p. 771, 1981.

LEGIONELLA:

Since the discovery of *Legionella pneumophilia,* several other forms of the organism have been isolated. The latest organism has been named *Legionella micdadei* (*L. pittsburgenesis*). *L. bozemanii, L. dumoffi,* and *L. longbeachae* are all Gram negative organisms and the infections caused by these respond well to the administration of erythromycin. *ANN INT MED,* Vol. 94, #6, p. 739, 1981.

CLODRONATE:

Clodronate disodium is an agent found to be effective in reducing osteoclastic bone resorption in animals and in patients with Pagets disease. The drug is used intravenously and is excreted primarily unchanged in the urine. *CLIN PHARM,* Vol. 30, #1, p. 114, 1981.

FERTILITY:

Women who are planning to have children in the future but who do not wish to conceive now are more likely to become pregnant later if they use oral contraceptive preparations rather than intrauterine devices. A study shows that future fertility may be altered if the IUD produces tubal damage and thus oral medication is recommended for women who ultimately want to plan a family. *LANCET,* Vol. I, #8234, p. 1329, 1981.

EMETICS:

Generally syrup of ipecac is used to induce vomiting, but it takes approximately 15 to 20 minutes to work. In addition, many households do not have the preparation on hand, and alternate methods of inducing vomiting need to be used. Mechanical induction of emesis is often ineffective and the use of sodium chloride solutions can be dangerous and has actually caused death. When no alternate means of inducing vomiting was available, patients were given dish washing detergent in solution. These worked quite well, but pre-school children tend to refuse to drink the solution. The products used included Ivory, Dove and Palmolive liquids. *CLIN TOXIC,* Vol. 18, #3, p. 277, 1981.

LEGIONNAIRES DISEASE:

Five years ago the term Legionnaires disease was coined to describe symptoms produced by an organism ultimately named *Legionella pneumophilia.* Today there are known to exist at least six serotypes of four newly recognized related organisms. Thus, the disease may be more common than thought. Patients complain of fever, malaise, chills and headache. Some coughing may be present and vomiting and diarrhea with abdominal pain is usually present. Temperatures are often above 102 degrees F and bradycardia may also be present. *AM FAM PHYS,* p. 165, July, 1981.

NITROGLYCERIN:

Patients with asthma were given sublingual nitroglycerin in efforts to determine if the smooth muscle relaxant might be beneficial in treating this respiratory disease. The drug did not seem to be effective and hypotension was seen after adminstration of the 1.2 mg dose. *J AM MED A,* Vol. 246, #2, p. 145, 1981.

MIGRAINE HEADACHE:

A new hypothesis has been presented to help explain the sequence of vasoconstriction and vasodilation associated with the migraine headache attack. It is suggested that the initial phase of vasoconstriction may be caused by a variety of substances or reactions, but that the net result is reduced blood flow and hypoxia. This is followed by reactive hyperemia or increased blood flow to the area. ATP and its breakdown products have been found in high concentration in the cerebrospinal fluid of patients during an attack, and the authors suggest that it is the ATP and its metabolites which cause the pain and dilation associated with the migraine attack. He further suggests that some analogs of ATP may have beneficial effects on migraine headaches. *LANCET,* Vol. II, #8235, p. 1397, 1981.

AQUAGENIC PRURITUS:

Certain people complain of itching when their skin comes in contact with water. Some of these individuals have been considered to be somewhat mentally unstable because there seems to be no obvious pathological damage or evidence of a reaction. Work in Great Britain has offered an explanation for this phenomenon. It appears that water can cause the release of acetylcholine in the skin of some patients, and in addition it appears that mast cells tend to degranulate during the attack. Further research shows that the plasma concentration of histamine is elevated during these attacks. It is suggested that patients with this type of aquagenic pruritus be treated with antihistamines to help prevent symptoms. *BR MED J,* Vol. 282, #6281, p. 2008, 1981.

ISOFLURANE:

Isoflurane is a non-flammable halogenated general anesthetic agent which is administered via the inhalation route. Although it has characteristics similar to those of halothane and enflurane, it produces more skeletal muscle relaxation than halothane and it does not have the central nervous system irritant effects of enflurane. Isoflurane is not extensively metabolized as are the other agents and it does not sensitize the myocardium to the effects of catecholamines. *J AM MED A,* Vol. 245, #22, p. 2335, 1981.

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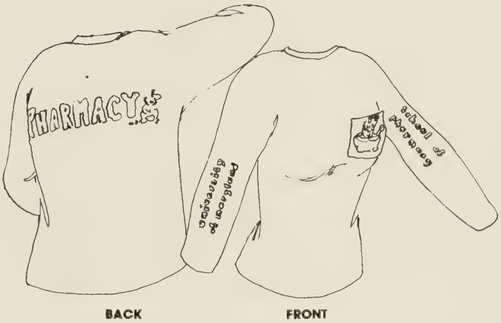

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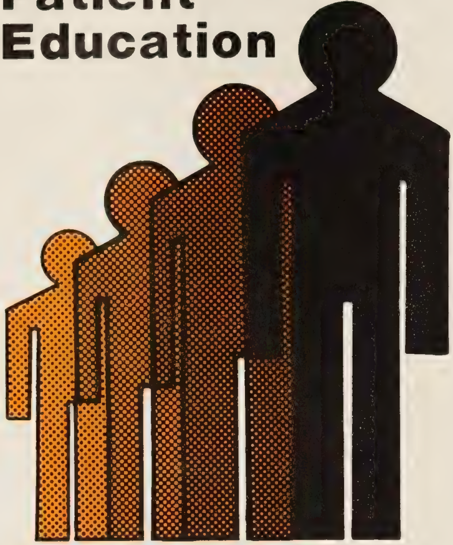

Expanding Pharmacists' Role

129th Annual Meeting
American Pharmaceutical Association

Las Vegas
April 24-29, 1982

Call it what you will, there's no denying the fact that we are in the midst of a revolution of sorts in this country. Patients are no longer content to accept blindly some vague directions typed on the prescription label; they are refusing to sit still for the "father knows best" attitude of many health care professionals.

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THE
MARYLAND
PHARMACIST
Official Journal of
The Maryland
Pharmaceutical
Association

April, 1982
VOL. 58
NO. 4

Formation of the Maryland State Pharmaceutical Association

— B. F. Allen, Ph.D.

Manufacturer Disclosure

A Brief History of USPHS Pharmacy in Maryland

— George F. Archambault

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President's Message

Why is it that so many outsiders are trying to legislate standards of practice for pharmacy? At the federal and state levels, bills have been introduced to require all practicing pharmacists to do what the profession has advocated for years. At this writing, none of the bills I am referring to have been passed. But consider the patient package insert argument. If we all routinely consulted with our patients, the issue would be moot. It is my understanding that five states have already passed legislation that will require consultation. In order to help us consult better, there is mandatory continuing education. Don't forget the mandatory patient profiles, etc.

The objective of all these requirements are worthy, but do they have to be mandated? Maybe so, if pharmacists do not respond on their own. I personally feel that we are moving in the right direction. Obviously, we are not moving quite fast enough to please everyone. Twenty years ago, who heard of patient profiles for pharmacies? Similarly, twenty years ago, it was very controversial to even let the patient know the name of the drug dispensed, let alone its pharmacological action. I can remember when good continuing education courses were few and far between. Now they are pervasive, although there is still room for more continuing education presentations in the non-metropolitan areas.

I agree with the principles behind the standards that will upgrade our profession, but I think they should be implemented voluntarily. What good is a patient profile when the overwhelming majority of patients in a particular practice are transient? If the pharmacist doesn't keep the profiles up-to-date or even neglects to use them regularly, who do they help? How much will a pharmacist learn in a continuing education course if he is forced to attend classes and chooses not to pay attention?

Legislation is not the answer. The answer must come from pharmacists motivating pharmacists to do what is right on their own volition.

Philip H Cogan

Philip H. Cogan,

President

1882 — 1982
SERVING THE PUBLIC HEALTH
MARYLAND PHARMACEUTICAL ASSOCIATION

Formation of the Maryland State Pharmaceutical Association

by B. F. Allen, Ph.D.

In 1882, the old Maryland College of Pharmacy gave birth to the State Association. At a Meeting of the College on October 5th, a statement was made that there was no organization in the State for the mutal protection of Pharmacists, and wholesale and manufacturing druggists. Therefore, the use of the College Building (east side of Aisquith Street, two doors north of Fayette Street, nine blocks directly east of City Hall) was offered as a place of meeting and twenty-five dollars authorized to defray the expenses.[1] (Note: the first state association—Maine—was founded on July 23, 1867[2]).

Also, at this meeting the Maryland College of Pharmacy President (Joseph Roberts, Manufacturing Chemist and Pharmacist, No. 1 Greenmount Avenue) offered a series of resolutions in regard to the formation of the Association and a fifteen member committee to be appointed. The following served on this Committee: Charles Caspari, Jr. (Professor of theory and practice of Pharmacy), Louis Dohme (Sharp and Dohme, southwest corner Pratt and Howard Streets), Edwin Eareckson (Pharmacy College Secretary, northeast corner Baltimore and High Streets), Columbus Emich (407 North Greene Street), N. Hynson Jennings (Pharmacy College Vice-President, 90 North Charles Street), Robert Lautenback (northeast corner Eutaw and Saratoga Streets), Samuel Mansfield (Pharmacy College Treasurer, southwest corner Baltimore and Schroder Streets[a]), J. Faris Moore (Professor of Botany and Materia Medica), J. E. Morrison, Joseph Roberts (Chairman), William S. Thompson (Member of first graduating class, Maryland College of Pharmacy 1842), Alonzo L. Thomsen (Manufacturing Chemist, Honover and Winder Streets), John J. Thomsen (importer of drugs, 251 West Baltimore Street), John H. Winkelmann (Wholesale Druggist, 45 South Sharp Street), T. Baird Wolf, M.D.[3],[4]

PREAMBLE AND RESOLUTIONS

Passed at a meeting of the
MARYLAND COLLEGE OF PHARMACY
Held October 5, 1882.

WHEREAS, The general progress and well-being of our profession demand that the Pharmacists everywhere be thoroughly organized, and

WHEREAS, The business relations existing between Pharmacists and Wholesale and Manufacturing Druggists are and ought to be of the most intimate and confidential character, and

WHEREAS, The Pharmacists, the Wholesale, and the Manufacturing Druggists have thus far had no organization in this State for their mutual protection, benefit, and the general advancement of pharmaceutical interests and knowledge:

THEREFORE, BE IT RESOLVED, That a committee of fifteen be appointed to correspond with and invite every Pharmacist, Wholesale and Manufacturing Druggist in the State to meet in the city of Baltimore on the second Tuesday of May next, to organize an association for the purpose set forth in the preamble.

BE IT FURTHER RESOLVED, That the said committee be and are hereby instructed to draft a suitable Constitution and By-Laws, to be submitted to the proposed association for their consideration, and that they do such other work as will, in their judgment, be useful to, and facilitate the speedy organization of the said proposed association.

BE IT FURTHER RESOLVED, That we cordially tender to the Pharmacists, the Wholesale and Manufacturing Druggists of the State the use of the College Building as a place of meeting.

The invitation to attend the meeting on the second Tuesday next (1883) was dated as of November 12, 1882 and carried the names of fifteen-member committee and Joseph Roberts or Charles Caspari, Jr. (Baltimore and Fremont Streets[b]) as the Sub-Committee on Correspondence.[6]

Baltimore, November 12, 1882

Dear Sir:

The undersigned Committee, acting in behalf of the Maryland College of Pharmacy, cordially invite you to meet in the city of Baltimore on the second Tuesday of May next at 11 o'clock A.M. at the hall of said College, for the purpose of organizing an Association of the Pharmacists, the Chemists, the Wholesale and Manufacturing Druggists of the State, for the general advancement of the science of Pharmacy, and the promotion of mutual interests.

---

[a] This Pharmacy Building (two and a half stories high) still stands today.

[b] Caspari's Drug Store at this location was on the northwest corner of Baltimore Street and Fremont Avenue. This building (three stories high) still stands today. Charles Caspari, Jr. became Dean at the Pharmacy College in 1896.

Be kind enough to advice the Committee if they may count upon your presence and hearty co-operation.

John J. Thomsen
Joseph Roberts
J. E. Morrison
Louis Dohme
John H. Winkelmann
W. S. Thompson
N. H. Jennings

Edward Eareckson
Charles Caspari, Jr.
J. Faris Moore
C. V. Emich
Samuel Mansfield
Alonzo L. Thomsen
R. Lautenbach

S. B. Wolfe

Address:
JOS. ROBERTS, No. 1 Greenmount Avenue,
or Chas. Caspari, Jr., Baltimore and Fremont Streets
Sub-Committee on Correspondence.

Your attention is respectfully called to a series of resolutions, under authority of which this call is issued.

In response to the call issued, twenty-five apothecaries (druggists and pharmacists) assembled at the Hall of the Maryland College of Pharmacy on Tuesday, May 8, 1883. Joseph Roberts called those present to order and on motion, Edwin Eareckson was elected as temporary Chairman with Charles Caspari, Jr. as Secretary Pro Tem. Roberts offered a resolution announcing those present as organized into a Maryland State Pharmaceutical Association, and moved the appointment of a committee to nominate permanent officers and to present a draft of a Constitution and By-Laws. Both resolutions were adopted.[7]

The Chair appointed the following committee for the purpose: from Baltimore, Joseph Roberts, Louis Dohme, and A. J. Corning; Levin D. Collier of Salisbury, and Hugh Duffy of Hillsboro. This Committee nominated the following gentlemen as permanent officers (and they were elected)[8]: President—John J. Thomsen (Baltimore), First Vice-President—C. W. Crawford (Gaithersburg), Second Vice-President—Thomas W. Shryer (Cumberland), Third Vice-President—Hugh Duffy (Hillsboro, Caroline County), Secretary—John W. Geiger (Baltimore), Treasurer—E. Walton Russell (Baltimore); Members of the Executive Committee—Samuel Mansfield (Baltimore), Joseph B. Boyle (Westminister), Henry A. Elliott[c] (Baltimore).

Joseph Roberts read a draft of the Constitution, which after being amended, was on motion of David M. R. Culbreth[d] (Ph.G., Maryland College of Pharmacy, 1879; M.D., College of Physicians and Surgeons, Baltimore, 1883) adopted as a whole. The newly elected President Thomsen was introduced (by the retiring Chairman) and delivered a prepared address.[11]

At the afternoon session on May 8th, the President appointed the following as members of the various committees—Legislation (Roberts, Hassencamp, Crawford, Moore, Eareckson), Pharmacy (Caspari, Louis Dohme, Shryer, Boyle, Thompson), Trade Interests (Alonzo L. Thomsen, Charles E. Dohme, Roberts, Duffy, Emich), Business (Mansfield, Geiger, Culbreth, Collier, Corning).[12]

It was also decided to enroll as members of this Association all reputable pharmacists and druggists who shall send in their names accompanied by the initiation fee and first year's dues on or before June 15, 1883.

The new Association Secretary, therefore, sent out the following letter:

MARYLAND STATE
PHARMACEUTICAL ASSOCIATION

****

Baltimore, May 12, 1883

Dear Sir:

Pursuant to a call, a number of Pharmacists, Druggists and Chemists of this State met in Baltimore on the 8th of this month, and organized themselves into the MARYLAND STATE PHARMACEUTICAL ASSOCIATION.

As it is desirable that every reputable Pharmacist of this State should become a member it was unanimously resolved to admit every Pharmacist and Druggist in good standing as a member, and enroll him as such after signing and sending in by mail enclosed application to the Treasurer, accompanied by three dollars, to pay the initiation fee and first year's dues; provided your application reaches the Treasurer On or before June 15th.

You are earnestly requested to join the Association.

Respectfully,

JOHN W. GEIGER,
Secretary

Before adjournment, delegates were elected to the following Associations: American Pharmaceutical Association—Louis Dohme, J. Faris Moore, John W. Geiger, Thomas W. Shryer, C. W. Crawford; National Association of Retail Druggists—Joseph Roberts, Charles Caspari, Jr., Edwin Eareckson, Samuel Mansfield; Virginia Pharmaceutical Association—Charles Caspari, Jr., J. Faris Moore, Herman I. Thomsen.

Members of the
Maryland State Pharmaceutical Association
1882–1883

Anderson, Geo. M.	Port Deposit, Md.
Betts, A. B.	Baltimore, Md.
Blaney, F. M.	Baltimore, Md.
Boyle, J. B.	Westminster, Md.
Burrough, Horace	Baltimore, Md.
Campbell, W. P.	Cumberland, Md.
Caspari, Chas. Jr.	Baltimore, Md.
Chisholm, Dan'l.	Oakland, Md.
Collier, Dr. Levin D.	Salisbury, Md.

---

[c] In January, 1853, Mr. Elliott opened a drug store on the southeast corner of Lexington and Pine Streets. He carried this on successfully for fifty years.[9] In 1886, a Maryland College of Pharmacy Committee (Thomsen, Elliott, Eareckson, Roberts) was appointed to investigate the advantages of various sites for the erection of a new Pharmacy College Building. After examining several sites, the Committee was extremely interested in a lot on the northside of Lexington Street just west of Pine Street.[10] Both of these locations are near the new University of Maryland School of Pharmacy, Northwest corner of Baltimore and Pine Streets.

[d] Dr. Gulbreth conducted a retail pharmacy at the northwest corner of Charles and Eager Streets for fifteen years.

Corning, A. J.	Baltimore, Md.
Coskery, H. J.	Catonsville, Md.
Crawford, C. W.	Gaithersburg, Md.
Davies, D. O.	Baltimore, Md.
Dickinson, Jas. A.	Baltimore, Md.
Dohme, Louis	Baltimore, Md.
Dodson, C. Marion	Baltimore, Md.
Duffy, Hugh	Hillsboro, Md.
Eareckson, Edwin	Baltimore, Md.
Edwards, Wm. F.	Baltimore, Md.
Elliott, Henry A.	Baltimore, Md.
Ely, Wm. R.	Baltimore, Md.
Emerson, Isaac E.	Baltimore, Md.
Emich, C. V.	Baltimore, Md.
Foster, J. Webb, Jr.	Baltimore, Md.
Geiger, John W.	Baltimore, Md.
Geoghegan, J. R., Jr.	Baltimore, Md.
Grote, Francis J.	Baltimore, Md.
Hassencamp, F.	Baltimore, Md.
Hayward, Thomas, S.	Easton, Md.
Henry, J. C.	Easton, Md.
Heinze, Otto B.	Baltimore, Md.
Hermann, J. G.	Cumberland, Md.
Horn, L. C.	Baltimore, Md.
Horstmann, Henry R.	Baltimore, Md.
Jennings, N. H.	Baltimore, Md.
Keller, W. L.	Baltimore, Md.
Kemp, R. H.	Trappe, Md.
Laney, H.	Cumberland, Md.
Leary, J. F.	Rock Hall, Md.
Manger, J. F.	Baltimore, Md.
Mansfield, Samuel	Baltimore, Md.
Merrick, Wm. S.	Trappe, Md.
Moore, H. C.	Baltimore, Md.
Moore, J. Faris	Baltimore, Md.
Muth, Geo. L.	Baltimore, Md.
Muth, John P.	Baltimore, Md.
Muth, M. Joseph	Baltimore, Md.
Myers, Joseph	Lonaconing, Md.
Nevill, W. R.	Woodberry, Md.
Passapae, Chas. D.	Baltimore, Md.
Pilson, A. O.	Baltimore, Md.
Pue, Chas. R.	Baltimore, Md.
Roberts, Joseph Dr.	Baltimore, Md.
Russell, E. Walton	Baltimore, Md.
Schroeder, Henry J.	Baltimore, Md.
Schrader, August	Baltimore, Md.
Shryer, Thos. W.	Cumberland, Md.
Simon, Prof. W.	Baltimore, Md.
Smith, T. W.	Ridgely, Md.
Stam, Colin F.	Chestertown, Md.
Stehl, Justus V.	Baltimore, Md.
Steiner, Henry R.	Frederick, Md.
Stewart, J. V. D.	Baltimore, Md.
Thomsen, Alonzo L.	Baltimore, Md.
Thomsen, Herman I.	Baltimore, Md.
Thomsen, John J.	Baltimore, Md.
Thomsen, J. J. Jr.	Baltimore, Md.
Thompson, W. S.	Baltimore, Md.
Truitt, Geo. W.	Salisbury, Md.
Truitt, Rufus K.	Salisbury, Md.
Webb, John A.	Baltimore, Md.
Weisel, John M.	Baltimore, Md.
Winkelman, John H.	Baltimore, Md.

The influence of the Association steadily grew. In 1883, there were seventy-three members, in 1884, ninety-six members, in 1885 one hundred and two members, and one hundred and nine in 1886. The 1884 meeting was held in the Hall of the Maryland College of Pharmacy (May 13–14): the 1885 meeting in the Academy of Music, Hagerstown (May 12–13); the 1886 meeting in the House of Delegates Chamber, State House, Annapolis (June 1); and the 1887 meeting in Ocean City (July 19).[15,16,17,18]

In 1904 the historical committee of the Association (John F. Hancock, Louis Schulze, Henry P. Hynson) reported that no published or unpublished records of the conventions held from 1887–1892 has been found.[e] The Committee reported that the meeting of 1893 was passed and the 1894 meeting held at the Blue Mountain House in Pen Mar was attended by a bare quorum and little more was done than elect officers.[19,20]

The historical committee of 1912 (Hynson and J. F. Hancock) reported finding additional information regarding lost meeting records.[21]

The articles of Incorporation of the "Maryland State Pharmaceutical Association of Baltimore City" dated twenty-sixth Day of November, in the year eighteen hundred and eighty-nine bear the names of the following as the incorporators:[23] D. C. Aughinbaugh, M. L. Byers, A. J. Corning, David M. R. Culbreth, M.D.[f], Edwin Eareckson, Columbus V. Emich, E. M. Foreman, Joseph P. Garrott, John W. Geiger, J. Walter Hodges, Samuel Mansfield, William Simon[g], J. Charles Smith, and John J. Thomsen.

The Association celebrated its fiftieth birthday at the Atlantic Hotel, Ocean City, June 21–24, 1932, The Masters of Ceremonies called the roll of those who had been members of the Association during its first year in 1882. No one answered present, and it was stated that of the fifty-four men (?) constituting the membership, only one, Henry R. Steiner, Frederick, was living. Mr. Steiner was in his eightieth year, but did not feel able to make the trip to the Ocean resort. However, he still was engaged in pharmaceutical work and operated his own drug store.[24]

William Ross Ely (Baltimore) also a member in 1882 died several weeks before the convention. E. M. Foreman was presented as the one of two survivors of the band of fourteen who incorporated the Association in 1889. Dr. D. M. R. Culbreth, the other living incorporator, found it impossible to attend. Mr. Foreman (Centerville) served as President of the Association in 1890. Also present at this affair were thirteen past presidents (in addition to Foreman).[25,26]

It is interesting to note the following: at a Maryland College of Pharmacy meeting the Board of Trustees on July 19, 1888 granted the M.S.P.A. the use of the College building for its coming meeteing.[27] On February 19, 1891, the Pharmacy College invited the members of the State Association to join in the festivities of the fiftieth anniversary of the College. The College Trustees also granted the M.S.P.A. the use of the College Building on Thursday, April 16, 1891.[28] At a meeting of the Board on October 15, 1891, the use of the College Building was tendered the M.S.P.A. for its annual meeting in November.[29] A meeting of the College was held on April 18, 1895 and President John F. Hancock of the M.S.P.A. applied for and was granted the use of the Building during the coming meeting of that body.[30] At this thirteenth annual meeting, a reception was held in the parlors of the Carrollton Hotel (light Street[31]) on Monday Evening, May 7th and the Association assembled in Alumni Hall of the Maryland College of Pharmacy, Tuesday, May 8th.[32]

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[e] The 1889–1892 meetings were held in Baltimore.[22]

[f] Professor of Botany, Materia Medica and Microscopy (Maryland College of Pharmacy).

[g] Professor of General Chemistry and Analytical Chemistry (Maryland College of Pharmacy).

It is noted that in the early years of the Association (MSPA), some of the officers were closely associated with the Maryland College of Pharmacy (MCP) in a variety of capacities. For example, John W. Geiger (southeast corner Pratt and High Streets) the first Secretary in 1883 (and again 1889–94) was also Secretary of the MCP for many years (1883–95). Samuel Mansfield Treasurer of MSPA during the period 1886–94 was treasurer also of the College for twenty-two years (1882–1904). Also, Edwin Eareckson President MSPA (1885), President MCP (1888–90); William Simon President MSPA (1887), Chemistry Professor MCP (1871–1904); Henry A. Elliott Third Vice President MSPA (1887), President MCP (1906–17): David M. R. Culbreth MSPA First Vice President (1889) and Treasurer (1896–98), Professor MCP (1885–1904); John F. Hancock MSPA Third Vice President (1890), President (1894) and Secretary (1895) President MCP (1873–75); Charles Caspari, Jr. First Vice President MSPA (1890), Professor and first Dean MCP (1879–1904); Henry P. Hynson MSPA First Vice President (1894), and President (1895), First Professor of Dispensing Pharmacy MCP (1900–04); Charles H. Ware Secretary MSPA (1897–99), Last President MCP (1907–08).[33,34,35,36,37]

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Harry Finke Honored

Harry Finke, member and owner of the Medicine Shoppe Pharmacy at 7116 Darlington Dr. in Baltimore recently received the International Franchise Association's Distinguished Achievement Award from Jerry Sheldon, President of Medicine Shoppe, International.

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calendar

April 24-29—APhA Convention, Las Vegas
June 6-10—ASHP Annual Meeting, Baltimore
June 18-20—MSHP Annual Seminar, Williamsburg
June 20-24—MPhA Centennial Convention, Ocean City
Nov 4-7—SAPhA Regional Convention, Baltimore

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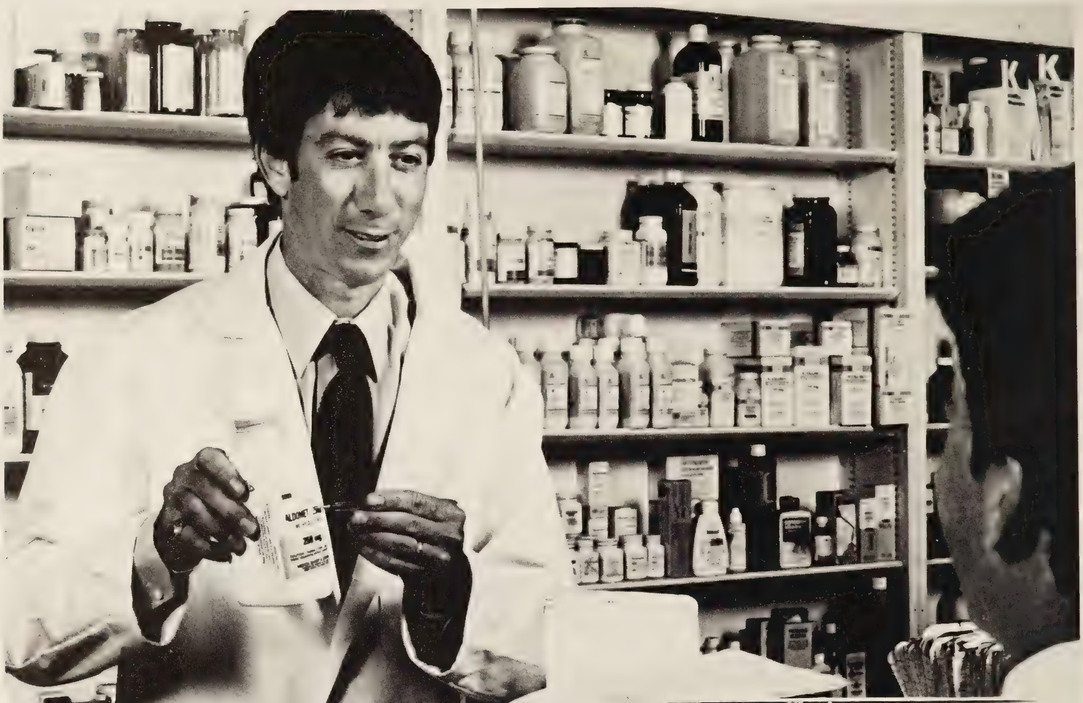

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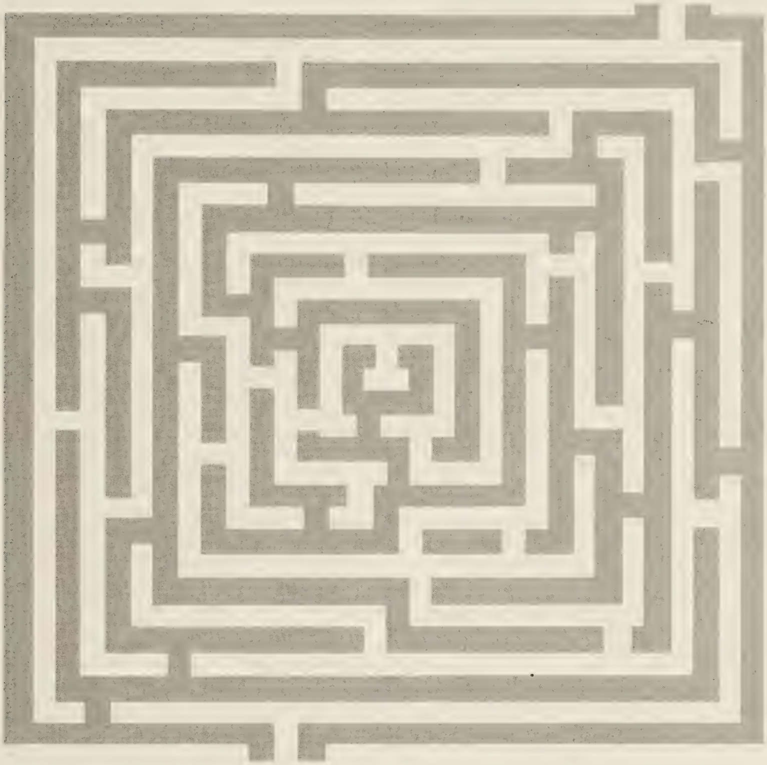
The R&D maze is a long and costly road to travel.



Luck does not bring life-saving products to market.... a well planned Research and Development Program does...but, the R&D maze is a long and costly road to travel. Recent studies indicate that it takes as much as 10 years and $70 million to bring a new medicine to market. This year Pfizer will spend over $200,000,000 on R&D in an effort to provide new products that are safe and effective and meet our high standards of quality. Pfizer's R&D commitment today helps to assure better health tomorrow.

Pfizer

PHARMACEUTICALS
Pfizer Laboratories, Roerig, Pfipharmecs

Manufacturer disclosure

To keep drug product selection a workable concept, pharmacists need information about the source of drug products before they purchase them.

The California Pharmacists Association wrote to drug manufacturers and distributors, asking them to provide new and updated information on which companies actually manufacture the final dosage form. On these pages is the latest information provided to the association.

We have added some drugs to the list because they are now available from a greater number of sources. All information concerning the manufacturers of drug products applies only to those dosage forms and strengths distributed by the companies. The distributor appears on the left, the manufacturer on the right.

Penicillin G 250 mg tabs and 125 and 250 mg liquid

H.R. Cenci Labs	Biocraft Labs
Coast Labs	Mylan Pharm.
Geneva Generics	Mylan Pharm.
Lederle Labs	Mylan Pharm.
McKesson Labs*	Mylan Pharm.
Parmed Pharm.	Biocraft Labs
Penta Products	Biocraft Labs
Pfipharmecs	Pfizer Pharm.
Purepac	Purepac
Rugby Labs	Mylan Pharm.
Smith Kline & French	Mylan Pharm.
E.R. Squibb & Sons	E.R. Squibb & Sons
Towne, Paulsen & Co.	Mylan Pharm. or Biocraft Labs
Vangard Labs*	Mylan Pharm.
West-Ward*	Biocraft Labs
Wolins Pharmacal*	Zenith Labs or Mylan Pharm. (tabs), Biocraft Labs
Wyeth Labs	Wyeth Labs

Penicillin V Potassium

Beecham Labs	Beecham Labs
Coast Labs	Mylan Pharm.
Geneva Generics	Mylan Pharm. or Biocraft Labs
ICN Pharm.*	Zenith Labs
Ladco Labs	Rugby Labs[1] or Mylan Pharm.
Lederle Labs	Lederle Labs
Eli Lilly & Co.	Eli Lilly & Co.
McKesson Labs*	Mylan Pharm.
Parke-Davis	John D. Copanos & Co.
Parmed Pharm.	Biocraft Labs
Penta Products	Biocraft Labs
Pfipharmecs	Pfizer Pharm.
Purepac	Purepac
Rexall Drug Co.	Biocraft Labs or Mylan Pharm.
A.H. Robins	Biocraft Labs
Rowell Labs	Biocraft Labs
Rugby Labs	Mylan Pharm.
Smith Kline & French	Mylan Pharm.
E.R. Squibb & Sons	E.R. Squibb & Sons
Towne, Paulsen & Co.	Mylan Pharm. or Biocraft Labs
The Upjohn Co.	The Upjohn Co.
Vangard Labs*	Biocraft Labs
West-Ward*	Biocraft Labs
Wolins Pharmacal*	Biocraft Labs or Zenith Labs (tabs), Mylan Pharm. (25 mg tabs)
Wyeth Labs	Wyeth Labs

Pentaerythritol Tetranitrate 10 and 20 mg tabs

H.R. Cenci Labs	Zenith Labs
Coast Labs	Bolar Pharm.
Geneva Generics	Bolar Pharm.
Invenex Pharm.*	Strong Cobb Arner
Ladco Labs	Rugby Labs[1] or Bolar Pharm.
McKesson Labs*	Zenith Labs
Parke-Davis	Parke-Davis
Parmed Pharm.	Zenith Labs or Bolar Pharm.
Penta Products	Bolar Pharm.
Purepac	Bolar Pharm.
Rugby Labs	Bolar Pharm.
Stayner Corp.	Bolar Pharm.
Towne, Paulsen & Co.	Towne, Paulsen & Co.
Vangard Labs*	Zenith Labs
West-Ward*	West-Ward
Wolins Pharmacal*	Bolar Pharm. or Zenith Labs

Phenobarbital 15, 30, 65 and 100 mg tabs

Barr Labs	Barr Labs
H.R. Cenci Labs	Cord Labs or Richlyn Labs
Drummer Labs	Lemmon
Geneva Generics	Cord Labs
ICN Pharm.*	ICN Pharm.
Invenex Pharm.*	Invenex Pharm.
Lederle Labs	Barr Labs
Eli Lilly & Co.	Eli Lilly & Co.
McKesson Labs*	McKesson Labs
Parke-Davis	Parke-Davis
Parmed Pharm.	Zenith Labs or Richlyn Labs
Penta Products	Barr Labs
Philips Roxane	Philips Roxane
Purepac	Purepac
Rugby Labs	Marshall Pharm.
Smith Kline & French	Philips Roxane
Vangard Labs*	Marshall Pharm.
West-Ward*	West-Ward
Wolins Pharmacal*	Danbury Pharmacal or Barr Labs
Wyeth Labs	Wyeth Labs

Phenylbutazone and Antacid caps

H.R. Cenci Labs	Premo Pharm.
Geigy Pharm.	Ciba-Geigy
Geneva Generics	Generic Pharm.
Ladco Labs	Premo Pharm.
Parmed Pharm.	Premo Pharm.
Penta Products	Zenith Labs
Rugby Labs	Chelsea Labs
Stayner Pharm.	Generic Pharm.
USV Labs	USV Labs
West-Ward*	Premo Pharm.

Phenylbutazone 100 mg tabs

Geigy Pharm.	Ciba-Geigy
Geneva Generics	Cord Labs
Parmed Pharm.	Premo Pharm.
Rugby Labs	Chelsea Labs
USV Labs	USV Labs

Phenytoin (Diphenylhydantoin)

H.R. Cenci Labs	Generic Pharm.
Coast Labs	Zenith Labs
Geneva Generics	Lannett Co. or Generic Pharm.
Ladco Labs	Rugby Labs[1]
Lederle Labs	Generic Pharm.

McKesson Labs*	Zenith Labs
Parke-Davis	Parke-Davis
Parmed Pharm.	Zenith Labs or Generic Pharm.
Penta Products	Generic Pharm.
Rugby Labs	Chelsea Labs
Vangard Labs*	Generic Pharm.
West-Ward*	Zenith Labs
Wolins Pharmacal*	Zenith Labs, Lannett Co. or Generic Pharm.

Pilocarpine eyedrops

Allergan Pharm.	Allergan Pharm.
Ayerst Labs	Ayerst Labs
Parmed Pharm.	Maurry Biological
Penta Products	Ketchum Labs
Rugby Labs	Ketchum Labs
Wolins Pharmacal*	Ketchum Labs

Potassium Chloride liquid 10% and 20%

H.R. Cenci Labs	H.R. Cenci Labs
Coast Labs	Chemrich Labs
Geneva Generics	Bay Labs
Lederle Labs	National Pharm.
Life Labs	Life Labs
Parmed Pharm.	National Pharm. or Bay Labs
Penta Products	Life Labs
Pfipharmecs	Pfizer Pharm.
Philips Roxane	Philips Roxane
Purepac	Purepac
Rugby Labs	Clay Park Labs, Newtron Pharm. or National Pharm.
Smith Kline & French	Philips Roxane
Stayner Corp.	Whiteworth
Towne, Paulsen & Co.	Towne, Paulsen & Co.
Vangard Labs*	National Pharm.
Wolins Pharmacal*	National Pharm. or Newtron Pharm.

Prednisolone 5 mg tabs

H.R. Cenci Labs	Zenith Labs or Richlyn Labs
Geneva Generics	Cord Labs
ICN Pharm.*	ICN Pharm.
Ladco Labs	Rugby Labs[1] or Chelsea Labs
McKesson Labs*	McKesson Labs
Parmed Pharm.	Zenith Labs, Danbury Pharmacal or Richlyn Labs
Penta Products	Zenith Labs
Pfipharmecs	Pfizer Pharm.
Philips Roxane	Philips Roxane
Purepac	Purepac
Rugby Labs	Chelsea Labs
Towne, Paulsen & Co.	Towne, Paulsen & Co.
The Upjohn Co.	The Upjohn Co.
Vangard Labs*	Generic Pharm.
West-Ward*	West-Ward

Prednisone 5 mg tabs

Barr Labs	Barr Labs
H.R. Cenci Labs	Halsey Drug Co.
Central Pharm.	Central Pharm.
Geneva Generics	Cord Labs or Barr Labs
ICN Pharm.*	ICN Pharm.
Ladco Labs	Rugby Labs[1] or Chelsea Labs
Lederle Labs	Danbury Pharmacal
McKesson Labs*	McKesson Labs
Parmed Pharm.	Richlyn Labs, Heather Drug Co. or Zenith Labs
Penta Products	Barr Labs
Philips Roxane	Philips Roxane
Purepac	Purepac
Rexall Drug Co.	Barr Labs
Rowell Labs	Rowell Labs
Rugby Labs	Chelsea Labs
Schering Corp.	Schering Corp.
Smith Kline & French	Philips Roxane
Stayner Corp.	Philips Roxane
Towne, Paulsen & Co.	Towne, Paulsen & Co.
The Upjohn Co.	The Upjohn Co.
Vangard Labs*	Generic Pharm.
West-Ward*	West-Ward
Wolins Pharmacal*	Ketchum Labs, Generic Pharm., Zenith Labs or Richlyn Labs

Probenecid with Colchicine tabs

H.R. Cenci Labs	Richlyn Labs
Geneva Generics	Zenith Labs
Ladco Labs	Rugby Labs[1] or Chelsea Labs
Lederle Labs	Danbury Pharmacal
McKesson Labs*	Richlyn Labs
Merck Sharp & Dohme	Merck Sharp & Dohme
Parmed Pharm.	Zenith Labs or Danbury Pharmacal
Penta Products	Danbury Pharmacal
Purepac	Richlyn Labs
Rugby Labs	Chelsea Labs
Stayner Corp.	Danbury Pharmacal
Towne, Paulsen & Co.	Danbury Pharmacal
West-Ward*	Danbury Pharmacal
Wolins Pharmacal*	Richlyn Labs or Zenith Labs

Probenecid 500 mg tabs

Geneva Generics	Mylan Pharm.
Ladco Labs	Rugby Labs[1]
Lederle Labs	Mylan Pharm.
McKesson Labs*	Mylan Pharm.
Merck Sharp & Dohme	Merck Sharp & Dohme
Penta Products	Danbury Pharmacal
Purepac	Mylan Pharm.
Rugby Labs	Mylan Pharm. or Chelsea Labs
Smith Kline & French	Mylan Pharm.
Stayner Corp.	Mylan Pharm.
Wolins Pharmacal*	Richlyn Labs or Zenith Labs

Procainamide 250, 375 and 500 mg caps

H.R. Cenci Labs	Bolar Pharm.
Coast Labs	Bolar Pharm.
Geneva Generics	Zenith Labs or Bolar Pharm.
Ladco Labs	Rugby Labs[1]
Lederle Labs	Danbury Pharmacal
Parke-Davis	Parke-Davis
Parmed Pharm.	Zenith Labs or Bolar Pharm.
Penta Products	Zenith Labs
Purepac	Bolar Pharm.
Rugby Labs	Chelsea Labs
Stayner Corp.	Danbury Pharmacal
E.R. Squibb & Sons	E.R. Squibb & Sons
Towne, Paulsen & Co.	Bolar Pharm. (250 & 500 mg) Danbury Pharmacal (375 mg)

Promethazine Expectorant with Codeine

H.R. Cenci Labs	H.R. Cenci Labs
Geneva Generics	Cord Labs or Bay Labs
Lederle Labs	National Pharm.
Life Labs	Life Labs
Parmed Pharm.	Bay Labs or National Pharm.
Penta Products	Life Labs
Purepac	Purepac or National Pharm.
Rugby Labs	Halsey Drug Co. or National Pharm.
Stayner Corp.	Cord Labs or Bay Labs
Towne, Paulsen & Co.	Towne, Paulsen & Co.
Vangard Labs*	National Pharm.

** No response was received from this company. The information listed has been taken from previous articles.*

[1] See the Rugby listing to determine the manufacturer of this product.

Wolins Pharmacal*	Bay Labs or National Pharm.
Wyeth Labs	Wyeth Labs

Promethazine Expectorant Pediatric

H.R. Cenci Labs	H.R. Cenci Labs
Geneva Generics	Bay Labs
Life Labs	Life Labs
Parmed Pharm.	National Pharm. or Bay Labs
Penta Products	Life Labs
Rugby Labs	Bay Labs or National Pharm.
Stayner Corp.	Bay Labs
Vangard Labs*	National Pharm.
Wolins Pharmacal*	National Pharm.
Wyeth Labs	Wyeth Labs

Promethazine Expectorant with Phenylephrine

H.R. Cenci Labs	H.R. Cenci Labs
Geneva Generics	Cord Labs or Bay Labs
Life Labs	Life Labs
Parmed Pharm.	National Pharm. or Bay Labs
Penta Products	Life Labs
Rugby Labs	Bay Labs or National Pharm.
Stayner Corp.	Bay Labs
Vangard Labs*	National Pharm.
Wolins Pharmacal*	National Pharm.
Wyeth Labs	Wyeth Labs

Promethazine Expectorant Plain

H.R. Cenci Labs	H.R. Cenci Labs
Geneva Generics	Cord Labs or Bay Labs
Lederle Labs	National Pharm.
Life Labs	Life Labs
Parmed Pharm.	National Pharm. or Bay Labs
Penta Products	Life Labs
Purepac	Purepac or National Pharm.
Rugby Labs	Bay Labs or National Pharm.
Stayner Corp.	Bay Labs
Towne, Paulsen & Co	Towne, Paulsen & Co.
Vangard Labs*	National Pharm.
Wolins Pharmacal*	National Pharm. or Bay Labs
Wyeth Labs	Wyeth Labs

Propantheline Bromide 15 mg tabs

H.R. Cenci Labs	Cord Labs
Coast Labs	Cord Labs
Geneva Generics	Cord Labs
Ladco Labs	Rugby Labs[1]
Lederle Labs	Mylan Pharm.
McKesson Labs*	Danbury Pharmacal
Parmed Pharm.	Bolar Pharm., Heather Drug Co. or Danbury Pharmacal
Penta Products	Danbury Pharmacal
Philips Roxane	Philips Roxane
Purepac	Purepac
Rugby Labs	Heather Drug Co. or Mylan Pharm.
Searle Pharm.	Searle & Co.
Smith Kline & French	Philips Roxane
Stayner Corp.	Cord Labs
Vangard Labs*	Heather Drug Co.
West-Ward*	Danbury Pharmacal
Wolins Pharmacal*	Mylan Pharm. or Danbury Pharmacal

Propoxyphene HCl 65 mg caps

H.R. Cenci Labs	Richlyn Labs
Coast Labs	Cord Labs
Geneva Generics	Cord Labs or Zenith Labs
ICN Pharm.*	ICN Pharm.
Ladco Labs	Rugby Labs[1] or Chelsea Labs
Lederle Labs	Lederle Labs
Eli Lilly & Co.	Eli Lilly & Co.
Parke-Davis	Parke-Davis
Parmed Pharm.	Zenith Labs, Richlyn Labs or Premo Pharm.
Penta Products	Barr Labs
Philips Roxane	Philips Roxane
Purepac	Purepac
Rugby Labs	Chelsea Labs
Smith Kline & French	Smith Kline & French
E.R. Squibb & Sons	Mylan Pharm.
Stayner Corp.	Cord Labs
Towne, Paulsen & Co.	Anabolic or Generic Pharm.
Vangard Labs*	Zenith Labs
West-Ward*	West-Ward
Wolins Pharmacal*	Zenith Labs, Premo Pharm. or Richlyn Labs

Propoxyphene HCl 65 mg compound caps

H.R. Cenci Labs	Zenith Labs
Coast Labs	Cord Labs
Geneva Generics	Cord Labs or Zenith Labs
ICN Pharm.*	ICN Pharm.
Ladco Labs	Rugby Labs[1] or Chelsea Labs
Lederle Labs	Lederle Labs or Mylan Pharm.
Eli Lilly & Co.	Eli Lilly & Co.
Parke-Davis	Parke-Davis
Parmed Pharm.	Zenith Labs, Cord Labs or Premo Pharm.
Penta Products	Zenith Labs
Philips Roxane	Mylan Pharm.
Purepac	Mylan Pharm.
Rugby Labs	Chelsea Labs
Smith Kline & French	Smith Kline & French
Stayner Corp.	Cord Labs
E.R. Squibb & Sons	Mylan Pharm.
Towne, Paulsen & Co.	Caribe Chem. Co. or Mylan Pharm.
Vangard Labs*	Zenith Labs
West-Ward*	Caribe Chem. Co.
Wolins Pharmacal*	Mylan Pharm., Premo Pharm., Zenith Labs or Richlyn Labs

Quinidine Sulfate 200 mg tabs

H.R. Cenci Labs	Zenith Labs
Geneva Generics	Cord Labs
Key Pharm.*	Key Pharm.
Ladco Labs	Rugby Labs[1] or Chelsea Labs
Lederle Labs	Barr Labs or Lederle Labs
Eli Lilly & Co.	Eli Lilly & Co.
McKesson Labs*	Danbury Pharmacal
Parke-Davis	Parke-Davis
Parmed Pharm.	Richlyn Labs, Zenith Labs or Danbury Pharmacal
Penta Products	Danbury Pharmacal
Philips Roxane	Philips Roxane
Purepac	Purepac
Rowell Labs	Rowell Labs
Rugby Labs	Chelsea Labs
Smith Kline & French	Philips Roxane
Stayner Corp.	Danbury Pharmacal
Towne, Paulsen, Co.	Carnegie Labs
Vangard Labs*	Carnegie Labs
West-Ward*	West-Ward
Wolins Pharmacal*	Zenith Labs, Blue Cross Products, Danbury Pharmacal or Chromalloy Pharm.

Reserpine 0.25 mg tabs

H.R. Cenci Labs	Richlyn Labs
Ciba	Ciba-Geigy
Coast Labs	Cord Labs
Drummer Labs	Lemmon
Geneva Generics	Cord Labs or Zenith Labs
ICN Pharm.*	ICN Pharm.
Ladco Labs	Rugby Labs[1] or Chelsea Labs

Lederle Labs	Danbury Pharmacal
Eli Lilly & Co.	Eli Lilly & Co.
McKesson Labs*	McKesson Labs
Parmed Pharm.	Zenith Labs or Barr Labs
Penta Products	Barr Labs
Philips Roxane	Philips Roxane
Purepac	Purepac
Rugby Labs	Chelsea Labs
Smith Kline & French	Philips Roxane
E.R. Squibb & Sons	E.R. Squibb & Sons
Towne, Paulsen & Co.	Towne, Paulsen & Co.
The Upjohn Co.	The Upjohn Co.
Vangard Labs*	Generic Pharm.
West-Ward*	West-Ward
Wolins Pharmacal*	Generic Pharm, Tablicaps, Chromalloy Pharm. or Zenith Labs

Spironolactone 25 mg tabs

Barr Labs	Barr Labs
H.R. Cenci Labs	Bolar Pharm.
Coast Labs	Bolar Pharm.
Geneva Generics	Cord Labs
Ladco Labs	Rugby Labs[1]
Lederle Labs	Mylan Pharm.
Parmed Pharm.	Zenith Labs, Bolar Pharm. or Cord Labs
Penta Products	Zenith Labs
Purepac	Bolar Pharm.
Rugby Labs	Chelsea Labs
Searle Pharm.	Searle & Co.
Stayner Corp.	Bolar Pharm.
Towne, Paulsen & Co.	Bolar Pharm.

Spironolactone with Hydrochlorothiazide

Barr Labs	Barr Labs
H.R. Cenci Labs	Bolar Pharm. or Zenith Labs
Coast Labs	Bolar Pharm.
Geneva Generics	Cord Labs
Ladco Labs	Rugby Labs
Lederle Labs	Mylan Pharm.
Parmed Pharm.	Zenith Labs, Bolar Pharm. or Cord Labs
Penta Products	Zenith Labs
Purepac	Bolar Pharm. or Mylan Pharm.
Rugby Labs	Chelsea Labs
Searle Pharm.	Searle & Co.
Stayner Corp.	Bolar Pharm.
Towne, Paulsen & Co.	Bolar Pharm.
Whiteworth	Bolar Pharm.

Sulfisoxazole 500 mg tabs

Barr Labs	Barr Labs
H.R. Cenci Labs	Cord Labs
Coast Labs	Cord Labs or Zenith Labs
Geneva Generics	Cord Labs
Hoffmann-La Roche	Hoffmann-La Roche
ICN Pharm.*	ICN Pharm.
Ladco Labs	Rugby Labs[1] or Chelsea Labs
Lederle Labs	Cord Labs
McKesson Labs*	McKesson Labs
Parmed Pharm.	Zenith Labs, Bolar Pharm. or Cord Labs
Penta Products	Barr Labs
Philips Roxane	Philips Roxane
Purepac	Cord Labs
Rugby Labs	Chelsea Labs
Smith Kline & French	Smith Kline & French
Stayner Corp.	Barr Labs
Towne, Paulsen & Co.	Dow Chem or Mylan Pharm.
The Upjohn Co.	The Upjohn Co.
Vangard Labs*	Cord Labs
West-Ward*	West-Ward
Wolins Pharmacal*	Heather Drug Co., Zenith Labs or Barr Labs

Sulfisoxazole and Phenazopyridine

H.R. Cenci Labs	Richlyn Labs
Coast Labs	Cord Labs or Richlyn Labs
Geneva Generics	Standard Pharmacal
Hoffmann-La Roche	Hoffmann-La Roche
Parmed Pharm.	Heather Drug Co.
Penta Products	Richlyn Labs
Philips Roxane	Richlyn Labs
Rugby Labs	Standard Pharmacal
Vangard Labs*	Standard Pharmacal
Wolins Pharmacal*	Richlyn Labs

Tetracycline HCl 250 and 500 mg caps and liquid

H.R. Cenci Labs	Richlyn Labs
Central Pharm.	Mylan Pharm.
Geneva Generics	Barr Labs, Zenith Labs or ICN Pharm.
ICN Pharm.*	ICN Pharm.
Invenex Pharm.*	Mylan Pharm.
Ladco Labs	Rugby Labs or Chelsea Labs
McKesson Labs*	McKesson Labs
Parke-Davis	Parke-Davis
Parmed Pharm.	Richlyn Labs, Heather Drug Co. or Pierrel America
Penta Products	Richlyn Labs or Zenith Labs
Pfipharmecs	Pfizer Pharm.
Purepac	Purepac
Rachelle Labs	Rachelle Labs
Rexall Drug Co.	Mylan Pharm.
A.H. Robins	A.H. Robins
Rugby Labs	Chelsea Labs
Smith Kline & French	Mylan Pharm. (caps) or McKesson Labs (syrup)
E.R. Squibb & Sons	E.R. Squibb & Sons
Towne, Paulsen & Co.	Towne, Paulsen & Co.
The Upjohn Co.	The Upjohn Co.
Vangard Labs*	Heather Drug Co. (caps) or National Pharm (liquid)
West-Ward*	West-Ward
Wolins Pharmacal*	Zenith Labs, Mylan Pharm., Heather Drug Co., Chromalloy Pharm. or Richlyn Labs
Wyeth Labs	Wyeth Labs

Theophylline tabs and caps, sustained or regular action

Central Pharm.	Central Pharm.
Geneva Generics	Vitarine Labs
Norwich-Eaton	Baylor Labs
Riker Labs	Riker Labs
Schering Corp.	K.V. Pharm.
Stayner Corp.	Central Pharm.

Theophylline, Ephedrine and Phenobarbital

H.R. Cenci Labs	Bolar Pharm.
Coast Labs	Cord Labs
Geneva Generics	Cord Labs or Zenith Labs
Invenex Pharm.*	Invenex Pharm. or Cord Labs
Parke-Davis	Parke-Davis
Parmed Pharm.	Cord Labs
Penta Products	Bolar Pharm.
Rugby Labs	Chelsea Labs
Stayner Corp.	Cord Labs
Towne, Paulsen & Co.	Towne, Paulsen & Co.
Vangard Labs*	Danbury Pharmacal (tabs) or National Pharm. (liquid)
West-Ward*	West-Ward
Wolins Pharmacal*	Drummer Labs or Chromalloy Pharm.

** No response was received from this company. The information listed has been taken from previous articles.*

[1] See the Rugby listing to determine the manufacturer of this product.

Thyroid 30, 65, and 120 mg tabs

Geneva Generics	Western Research Labs
ICN Pharm.*	ICN Pharm.
Invenex Pharm.*	Invenex Pharm.
Lederle Labs	Western Research Labs
Eli Lilly & Co.	Eli Lilly & Co.
Marion Labs	Parke-Davis
McKesson Labs*	McKesson Labs
Parmed Pharm.	Richlyn Labs, Heather Drug Co. or Bowman
Penta Products	Barr Labs
Purepac	Purepac
Rugby Labs	Marshall Pharm. or Chelsea Labs
Vangard Labs*	Western Research Labs
West-Ward*	West-Ward
Wolins Pharmacal*	Generic Pharm. or Chromalloy Pharm.

Tolbutamide 500 mg tabs

Barr Labs	Barr Labs
H.R. Cenci Labs	Premo Pharm.
Geneva Generics	Cord Labs or Mylan Labs
Ladco Labs	Rugby Labs[1]
Lederle Labs	Lederle Labs or Mylan Pharm.
Parmed Pharm.	Premo Pharm. or Zenith Labs
Penta Products	Zenith Labs
Purepac	Cord Labs
Rexall Drug Co.	Mylan Pharm.
Rugby Labs	Chelsea Labs
Smith Kline & French	Smith Kline & French
Stayner Corp.	Mylan Pharm.
E.R. Squibb & Sons	Mylan Pharm.
Towne, Paulsen & Co.	Mylan Pharm.
The Upjohn Co.	The Upjohn Co.

Triamcinolone cream or ointment

Geneva Generics	Thames Pharm.
Ladco Labs	Rugby Labs[1]
Lederle Labs	Lederle Labs
Parmed Pharm.	Premo Pharm.
Rugby Labs	Clay Park Labs
Smith Kline & French	Philips Roxane
E.R. Squibb & Sons	E.R. Squibb & Sons
Wolins Pharmacal*	Premo Pharm.

Trihexyphenidyl HCl 2, 5 mg tabs

H.R. Cenci Labs	Bolar Pharm.
Coast Labs	Bolar Pharm.
Geneva Generics	Bolar Pharm.
Ladco Labs	Rugby Labs[1]
Parmed Pharm.	Bolar Pharm.
Penta Products	Danbury Pharmacal
Rugby Labs	Bolar Pharm. or Danbury Pharmacal

Trihexyphenidyl HCl 2 and 5 mg tabs

Schering Corp.	Schering Corp.
Stayner Corp.	Danbury Pharmacal
Towne, Paulsen & Co.	Bolar Pharm.
Whiteworth	Bolar Pharm.

Triprolidine and Pseudoephedrine tabs, elixir or expectorant

Burroughs Wellcome Co.	Burroughs Wellcome Co.
H.R. Cenci Labs	Generic Pharm. or Zenith Labs (tabs) or H.R. Cenci Labs (liquid)
Coast Labs	M.D. Pharm.
Geneva Generics	Bay Labs
Ladco Labs	Premo Pharm. (tabs) or Barr Labs (syrup)
Parmed Pharm.	Bay Labs, National Pharm., Premo Pharm. or Cord Labs
Penta Products	Life Labs
Philips Roxane	Philips Roxane
Purepac	Bolar Pharm. (tabs) or National Pharm. (syrup)
Rugby Labs	Bay Labs or National Pharm.
Stayner Corp.	Generic Pharm. (tabs) or Bay Labs (syrup)
Towne, Paulsen & Co.	National Pharm.

Triprolidine and Pseudoephedrine with Codeine Expectorant

Burroughs Wellcome Co.	Burroughs Wellcome Co.
H.R. Cenci Labs	H.R. Cenci Labs
Geneva Generics	Cord Labs or Bay Labs
Life Labs	Life Labs
Penta Products	Life Labs
Rugby Labs	National Pharm. or Halsey Drug Co.
Stayner Corp.	Bay Labs
Vangard Labs*	National Pharm.
Wolins Pharmacal*	National Pharm.

APhA Appoints Task Force on Pharmacy Education

The Board of Trustees of the American Pharmaceutical Association (APhA) has appointed a Task Force on Pharmacy Education which will conduct a comprehensive review and analysis of all aspects of pharmaceutical education.

Among the issues the group will address are the content and length of the pharmacy curriculum leading to the entry degree, the title of that degree, the type of training required for licensure, education and training at the post-entry degree level, and the awarding of external degrees.

Eminent educators John C. Weaver of Los Angeles, California, and Lloyd M. Parks of Columbus, Ohio, will head the task force as chairman and vice chairman, respectively.

Cancer Society Elects Freedenberg

At it's recently held Annual Meeting, the American Cancer Society, Maryland Division, Inc. installed Marvin Freedenberg, P.D. as Chairman of the Board of Directors.

The 163 volunteer members comprising the House of Delegates, elected Mr. Freedenberg for a term of two years. Mr. Freedenberg has been a volunteer for the American Cancer Society for 13 years, being active at the community and state level. He has held numerous positions of leadership including Montgomery County Patient Service Chairman, Montgomery County President, State Budget and Finance Chairman, State Public Issues Chairman and State Vice Chairman of the Board.

Mr. Freedenberg is co-owner of Drug Lane Pharmacy and is affiliated with the Prince George's-Montgomery Pharmaceutical Association. He is a Fellow of the American Society of Consultant Pharmacists. He and his wife, Margie, live in Silver Spring.

Now you can get Blue Cross and Blue Shield coverage regardless of your health

OPEN ENROLLMENT

Now, during a special Open Enrollment period, you can obtain Blue Cross and Blue Shield group coverage through the Maryland Pharmaceutical Association. It's ANOTHER BENEFIT OF MPhA MEMBERSHIP.

Even if you've been unable to obtain coverage in the past, now you can. And no personal health statements or medical questionnaires are required for membership. You will be accepted automatically.

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Department 114

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The Industry Relations Committee Says:

Make April The Month You Clean Out Dated Merchandise

The Industry Relations Committee of the Maryland Pharmaceutical Association formed a subcommittee to study the issue of a Model Return Goods Policy. It was the feeling of the Committee, which is made up of manufacturing representatives and practicing pharmacists, that the policy should be fairly comprehensive and yet, provide some guidance and consistency in this area. The goal of the Committee was to develop a policy which could be endorsed by the Association in an attempt to establish a standard and which would be acceptable to both manufacturers and retailers.

The Committee recommends that members retain this page from the journal and refer to the following MPhA adopted policy whenever a question concerning returning merchandise arises. In addition, the Industry Relations Committee serves as an ombudsman whenever members refer a problem concerning this subject in writing to it.

MODEL RETURN GOODS POLICY

1. **New prescription drug products shipped to the pharmacy automatically by the manufacturer or wholesaler may be returned at any time for credit or exchange.**
2. **Regardless of expiration dates products may be returned for credit or exchange at any time, providing they are sealed, intact, original packages.**
3. **For patient protection, open packages of prescription drug products which are outdated may be returned for at least partial credit.**
4. **Authority for returns may be required by the pharmaceutical manufacturer or wholesaler—a form should be provided to the pharmacy.**

SAMPLE FORM to Return Merchandise

TO:(Name of Manufacturer)
Address—including the name of Town, County, State and Zip Code

(Note—the above as well as the policy for making returns may be located in the NWDA list of Mfgs. in January 1977 edition of the American Druggist Blue Book).

Please grant us authorization to return the following pharmaceuticals of your manufacture as per your policy:

It is best to list the items—listing complete packages as well as open containers. If a return of a schedule 2 is requested, be sure to give exact count and hold these aside as they usually will send a narcotic form. (Because of mail rates, it may be less expensive to have the drug inspectors destroy them.)

Note—If in their reply, they say they do not accept open containers—or—partially filled ones, call their attention to the fact that for the protection of the patient, as well as the pharmacist and the manufacturer, you believe it best they change their policy to permit them to accept them for credit.

Mary Ann Frank (left), bookkeeper for the MPhA for the past twenty years, receives the Honorary President's Plaque from BMPA President Frank Marinelli (right) for her service to the profession of pharmacy.

Toastmaster Elwin Alpern, (left) presents President Frank Marinelli with the NARD Leadership Award.

The BMPA Banquet was held February 14, 1982 at the Blue Crest North in Baltimore with over 250 pharmacists, family and friends in attendance.

Chairman of the MPhA Centennial Celebration Committee, William Skinner makes a few announcements at the Banquet. The BMPA banquet helped to kick-off the year-long Centennial Celebration.

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A Brief History of USPHS Pharmacy in Maryland

George F. Archambault

INTRODUCTION

William Skinner, pharmacist and attorney, long active in the affairs of the Maryland Pharmaceutical Association, has requested that I compile a brief history of U.S.P.H.S. Pharmacy in Maryland for inclusion in *The Maryland Pharmacist* relative to the celebration of the Association's first hundred years of existence. This is that history. It has been compiled with the help of many PHS pharmacists, some retired and others on active duty. Where possible "credit lines" are given. It is hoped that this short history will help serve to record for posterity the USPHS's activities of pharmacists and pharmacy in Maryland.

For the sake of easy identification, the activities are segregated as follows:

Chapter 1. U.S.P.H.S. Hospital, Baltimore, MD (formerly U.S. Marine Hospital)
Chapter 2. The USPHS Perry Point Depot
Chapter 3. The Pharmacy at the Clinical Center, National Institute of Health (NIH)
Chapter 4. Pharmacists serving in other non-Pharmacy government activities in Maryland.
Chapter 5 thru 14 Miscellaneous (Activities and Ranks)

PART 1

The USPHS Hospital, Baltimore, MD

We are indebted to Karl H. Holtgreve, a well known pharmacist in Maryland Pharmacy circles for the following list of Chain of Commands and years of service at the hospital's Pharmacy Department.

CHIEF PHARMACIST
U.S. PUBLIC HEALTH SERVICE HOSPITAL
Baltimore, Maryland, 21211

Prior to 1942	Records not available
Hanna, William M.	1942–1950
Scigliano, John A.	1950–1952
Dodds, Arthur W.	1952–1956
Proper, Robarts	1956–1957
Wolfthal, Abraham	1957–1961
Crisalli, Joseph P.	1961–1962
Gladhart, Wesley R.	1962–1965
Lesage, Paul J.	1965–1970
Johnson, Kent T.	1970–1978
Tonelli, Robert	1978–1982

DEPUTY CHIEF PHARMACIST
U.S. PUBLIC HEALTH SERVICE HOSPITAL
Baltimore, Maryland, 21211

Prior to 1950	?
Ames, Reed	1950–1951
Brands, Allen	1951–1952
Verhulst, Louis	1952–1953
Bolte, Richard	1953–1955
Baughman, Bertram	1956–1957
Holtgreve, Karl H.	1957–1973
Walker, Thomas	1973–1974
Buehler, Gary	1974–1979
West, Robert	1979–1982

CHIEF PHARMACISTS
U.S. PUBLIC HEALTH SERVICE
OUT-PATIENT CLINIC
U.S. Custom House
Baltimore, MD 21201

Hens, Louis L.	1933–1937
Holtgreve, Karl H.	1937–1950

After 6-1-50, Pharmacy service was supplied directly by the Baltimore PHS Hospital and this clinic was closed.

PHARMACY RESIDENCY APPOINTMENTS[1]

Maryland Pharmacists receiving Pharmacy Residency Appointments and Commissions as USPHS Officers:

West, Robert L.	Univ. of Maryland	1970
Jarosinski, Paul F.	Univ. of Maryland	1976
Shawger, Christopher L.	Univ. of Maryland	1976
Clark, Larry C.	Univ. of Maryland	1977
Brophy, Margaret C.	Univ. of Maryland	1977
Melito, Mary P.	Univ. of Maryland	1980
Meyer, Mary A.	Univ. of Maryland	1980

[1] Information supplied by Pharmacist Director Richard J. Bertin, Ph.D., Deputy Chief, Professional Services Branch, Division of Hospitals and Clinics, BMS, USPHS.

HISTORY OF PHARMACISTS IN THE U.S.P.H.S.[2]

"Until the turn of the present century, physicians and pharmacists were the only professionally trained persons employed in the Service hospitals and health activities. Pharmacists have been employed in the Service since its very beginning, under a variety of designations, i.e., apothecary, hospital-steward, pharmacist and chemist, pharmacist, and medical purveyor, each designation comprising one or more grades. Graduation in pharmacy before appointment was first required in 1897.

---

[2] This over all history of pharmacists U.S.P.H.S. is taken from R. C. William's text "The United States Public Health Service 1798–1950," p. 529–532.

Whatever his designation, the duties of a Service pharmacist, until 1945, were both administrative and professional. They were the technical administrative officers of the Service, and at hospitals, quarantine stations, and the like, the senior pharmacist served as lay superintendent, receiving general direction from the medical officer in charge to whom he was responsible. In these duties and assignments pharmacists have performed services of marked importance in the fields of hospital planning and operation; budget, personnel, and supply management, physical maintenance of buildings, ships, and equipment; sanitary inspection, fumigation, rat-proofing of ships; research; and as disbursing and contracting officers. As with all officers of the Service, pharmacists are required to maintain their professional fitness regardless of assignment. Despite their other tasks, their functions have always included significant pharmaceutical responsibilities.

Experience over many years has shown the expediency and effectiveness of having a mobile corps of pharmacists. For the proper performance of their remarkably varied duties, they must have a broad understanding of the methods and functions of the Service, an understanding gained only by training and background of actual participation in field work. Thus, it is the practice to assign pharmacists, upon appointment, to the smaller stations, and later transfer them to more important posts as they become familiar with the Service and as their abilities develop. The availability of the individual pharmacist for whatever duty might be assigned to him and the changes of duty and station have the collective effect of creating a permanent mobile corps of trained pharmacist officers who are essential to effective operation of Service activities.

As the Service expanded through the years, pharmacists have served at most of its field stations, including hospitals,* quarantine stations, supply depots, research stations, and the like, both in the United States and abroad; and pharmacists have been detailed for duty at the Headquarters of the Service where one or more such officers have been on duty since 1894, when by law the Surgeon General was authorized to detail "one hospital steward for duty in the Bureau." A number of pharmacists served on yellow fever epidemic duty in charge of fumigation of houses, bedding, and clothing. Frequently they were assigned to inspections and administrative duties during various epidemic campaigns.

As may be expected in a Service primarily concerned with medical care and public health, the function dealing with the procurement and distribution of medical and related supplies is one of importance. The Supply Division, originally known as the Purveying Division and later the Purveying Service, was one of the first organizational segments established. The officer in charge of the Purveying Division was designated the Medical Purveyor. The Regulations of 1879 required the Medical Purveyor to be a skilled pharmacist and his compensation was the same as that of a surgeon of the Service. This officer also served as a member of the Advisory Board (or Service Board) whose function was to consider matters referred to it relating to Service Personnel and the work of the marine hospitals. The first Medical Purveyor was Dr. Oscar Oldberg, a pharmacist. He was appointed as Chief Clerk and Acting Medical Purveyor on July 10, 1877. On September 6, 1879, the office of the Chief Clerk was abolished and Doctor Oldberg was then appointed as Medical Purveyor.

The early regulations of the Service required candidates for appointment as hospital-steward to be "sufficiently . . . skilled in pharmacy and bookkeeping to perform duties of apothecary as well as steward, whenever necessary." the requirement that hospital-stewards be qualified in pharmacy was occasioned by reasons of economy and operation efficiency.

The need for active Service participation and interest in the revision of the Pharmacopeia of the United States as a public health measure was early recognized, and the Service has been regularly represented at each decennial meeting of the Pharmacopoeial Revision Convention held since the reorganization of the Service in 1871. The 1950–1960 Revision Convention had, in its membership, a Service pharmacist officer, George F. Archambault, as one of the delegates in addition to other Service representatives. This officer has also been elected to membership in the Revision Committee to serve on the five-man Prescription Board of the Pharmacopoeia fôr the ensuing ten-year period. It is believed that this is the second such recognition of a pharmacist of the Service, Martin I. Wilbert, of the Division of Pharmacology of the Hygienic Laboratory, having served as a Revision Committee member for the U.S.P. IX in 1910.

A betterment of special import to pharmacy resulted from the approval on April 9, 1930, of the "Parker Act" which provided for the coordination of public health activities of the Government. This law included provision for the appointment of pharmacists in the commissioned corps with promotion up to and including the grade corresponding to Army Captain. During the years 1930–1933, 11 pharmacists were commissioned pursuant to the Act. A further and substantial improvement in the status and opportunity for pharmacists in the Service occurred upon the approval of the Public Health Service Act of 1944 (Public Law 410—78th Congress). Under this Act the promotion limitation was lifted and pharmacists may now be promoted to the Director

---

* Originally named U.S. Marine Hospitals, changed in the 1950s to U.S. Public Health Service Hospitals to better describe their identity.

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grade corresponding to that of Army Colonel. Promotions to the Senior and Director grades are made on a selective and competitive basis for a limited and predetermined number of such positions. The first Pharmacist Director of the Service, Mr. Raymond D. Kensey, was appointed temporarily by promotion in July, 1949."

Current Activities (1982) of the Baltimore and other PHS hospitals and the role of pharmacists:[3]

The Baltimore hospital, along with all other PHS hospitals and clinics, was phased out in early 1982 under the Reagan's Administration government-wide budget cuts. Today, no longer a federal facility it continues to serve much the same type of patients as a non-profit local institution known as Wyman Park Health System.

"The U.S. Public Health Service Hospital in Baltimore as of July, 1981 was accredited for the last time before its closure as a PHS hospital by the Joint Commission on Accreditation of Hospitals. It provided services within the city as well as in 11 states by means of six satellite ambulatory care centers and 70 contract care physicians. It was a division of the Bureau of Medical Services of the Department of Health and Human Services and was funded primarily by an annual congressional appropriation.

The hospital served three categories of beneficiaries:

1. statutory federal beneficiaries including American seamen, PHS officers, Coast Guard and National Oceanic and Atmospheric Administration personnel;
2. other federal beneficiaries such as active-duty and retired personnel in the uniformed services, and their dependents; and
3. community beneficiaries such as Baltimore residents who come from medically underserved areas.

The purpose of the Baltimore PHS hospital was to provide accessible, quality health care at reasonable cost to the beneficiaries served. In trying to fulfill this mission, the hospital was undergoing a major transition from a traditional medical hospital to a comprehensive health system facility. The comprehensive system emphasized ambulatory services, preventive as well as therapeutic medicine, integration of multiple health and social services, and support to and involvement with community health programs.

National Health Emergencies

The participation in National Health Emergencies was demonstrated most recently during the recent Cuban refugee crisis, the Baltimore PHS Hospital sent 6 nurses, 16 physicians, 3 administrators, and several pharmacists to various refugee centers from Florida to Pennsylvania. These health professionals were available on short notice, and along with staff from other USPHS hospitals, demonstrated once again the capacity of PHS commissioned officers to mobilize their talents to provide quality medical services in emergencies anywhere in the country, in fact in the world, wherever emergency health problems and epidemics arise.

Utilization

As to utilization, the hospital's statistics for the past five years (1976–1980) are quite revealing. In keeping with modern health care trends, inpatient day care is decreasing (from 15.9 to 9.7 days) and out-patient (maintenance and other) care is increasing (from 104 303 visits to 127 515).

Pharmacy's Role

As to the system's pharmaceutical contribution to patient care and national public health, the facts are impressive. Back in 1953, one of the first national hospital formularies was issued by the PHS hospitals, "BASIC DRUGS—USPHS HOSPITALS AND CLINICS," an approach much copied by other hospitals throughout the nation. Again, when the American Society of Hospital Pharmacy residencies were in their infancy, PHS hospitals were among the first to have approved residencies. To date, via the residency system and its offshoots, the pharmacy officer Commissioned Corps is about 600 strong, with a chief pharmacist of flag rank and pharmacist billets at the National Institute of Health, Food and Drug Administration, Division of Indian Health, National Library of Medicine, and other key PHS locations throughout the nation. In addition, there are hundreds of well-trained hospital pharmacists who have departed from PHS hospitals to pursue careers in civilian hospitals, extended care facilities, national and state associations, academia, and other pharmacy and health administration leadership positions."

During the latter years of the U.S.P.H.S. Hospital's existence, the pharmacy profession accepted its role in clinical pharmacy, i.e., the nursing units had satellite pharmacies and "unit-of-use" doses were dispensed to patients. The PHS pharmacists were in the forefront of these endeavors. The Baltimore PHS Hospital was the first of the federal hospitals (military and veterans) to have pharmacists on nursing units full time, and among the first to initiate the service of preparing and dispensing "unit-of-use" medication to each patient through the pharmacy.

Publications

Two publications prepared by pharmacist officers and others are of historical significance:

(1) *"1953 BASIC DRUGS"*—USPHS Hospital's first Division Wide Formulary—Key Compilers were:

Clifton K. HimmelsBach, M.D. Medical Officer in

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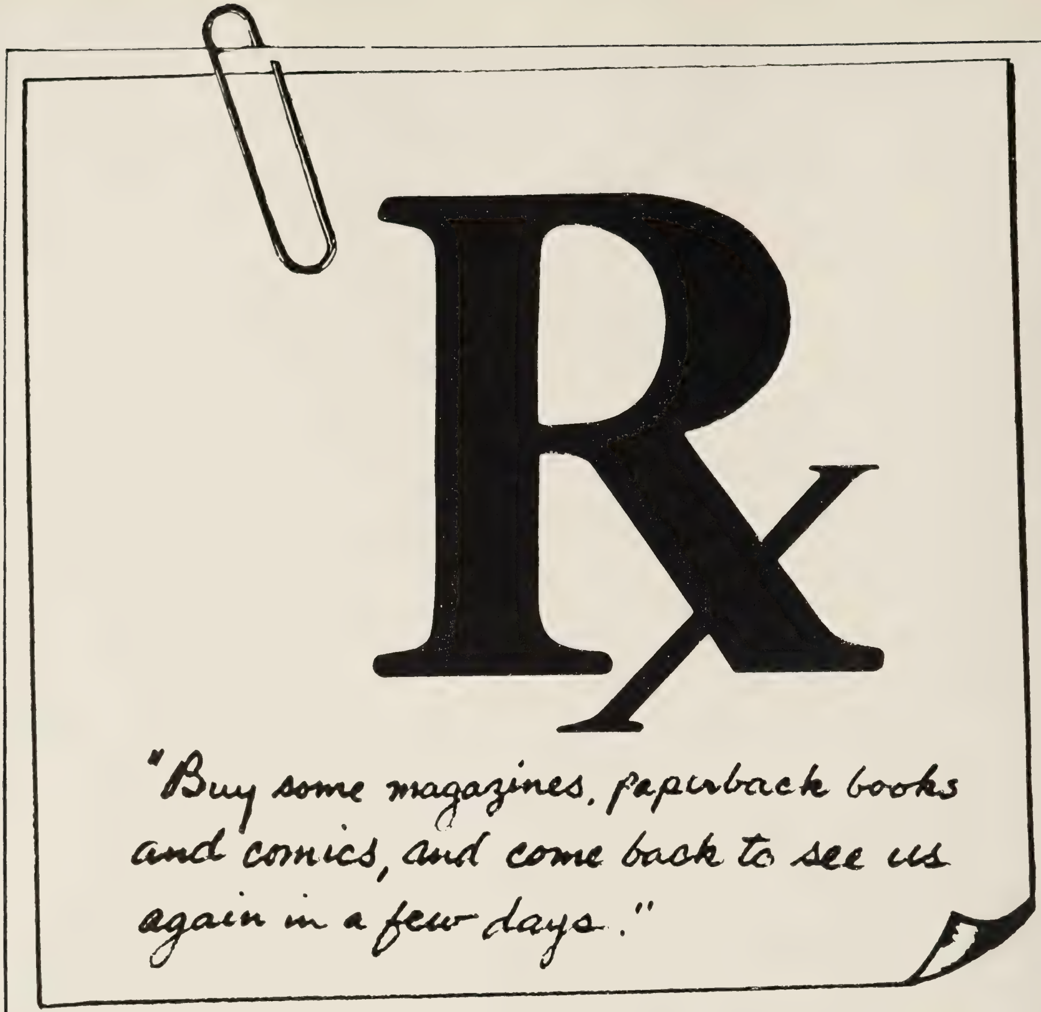
[3] Updated from an editorial by G. F. Archambault Appearing in Drug Intelligence and Clinical Pharmacy Journal, July–Aug., 1981 issue entitled "In Defense of Eight Public Health Service Hospitals and Their 29 Satellite Clinics."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charge of USPHS Out-Patient Clinic, Washington, D.C.

Jack Mordell, Pharmacist Director, Pharmacy Service OPC Washington, D.C.

John Wilson, M.D., Clinical Director, USPHS Hospital, Baltimore, MD

William Hanna, Chief, Pharmacy Service, USPHS Hospital Baltimore, MD along with G. Halsey Hunt, M.D., Assistant Surgeon General and Assoc. Chief, Bureau of Medical Services, PHS and George F. Archambault, Chief, Pharmacy Branch, Division of Hospitals USPHS as coordinators.

(2) *THE SHIP'S MEDICINE CHART AND MEDICAL AID AT SEA—1978*—a text book of "Medical Advice by Radio"—a service provided by the hospitals and out-patient clinics of the USPHS. HEW Publication No. (HSA) 78-2024. U.S. Government Printing Office, Washington, D.C. This text is a revision of PHS publication number 9 "The Ship's Medicine Chest and First Aid At Sea," reprinted with additions and changes in 1955, Pharmacist Director Arthur W. Dodds (USPHS Retired) was one of the key architects of the 1978 revision along with Richard Bertin, Pharmacist Director, former Chief Pharmacy Branch, Div. of hospitals, currently on active duty at PHS CO headquarters in Rockville, MD. G. F. Archambault, Pharmacist Director played a key role in the 1955 revision as it related to drug uses on merchant marine ships.

PART 2

The PHS Medical Supply Depot—Perry Point, MD

Brief History

The first period of a supply type operation for the Public Health Service is indicated as 1892. This activity was known as the U.S. Public Health Service Purveying Depot and was located in Washington, D.C. The next supply function of record was a Purveying Depot located in New York City, New York in 1899, to provide commonly used supply items for the then Marine Hospital Service.

In the early part of the 20th century supply activities were expanded with the establishment of a Purveying Depot in North Chicago, Illinois and a Purveying Depot at Perryville, Maryland. This latter establishment was the precursor of the current PHS Supply Service Center and was located on the grounds of U.S. Public Health Service Hospital No. 42 at Perryville, Maryland.

By Executive Order of President Warren G. Harding, dated April 29, 1922, a number of PHS hospitals including Hospital No. 42 were turned over to the newly created Veterans Administration. In the same executive order, President Harding specified that buildings and supplies at the USPHS Purveying Depots at North Chicago, Illinois and at Perryville, Maryland be allocated between PHS and VA on the basis of future needs. This ultimately resulted in a 20%–80% split—20% for PHS and 80% for VA.

As a result of the action ordered by President Harding all supply operations were consolidated into several buildings on the ground of the Veteran's Administration Hospital, Perry Point, Maryland and renamed the PHS Supply Station.

In 1953, when the Public Health Service became part of the newly formed Department of Health, Education, and Welfare the station was renamed the PHS Medical Supply Depot. It retained this name until 1964 when it was redesignated as the PHS Supply Service Center.

Available records demonstrate that from 1922 through 1978 the director at the facility was always a PHS Pharmacist as shown in the following listing of the pharmacists who have held that position:

Year	*Incumbent*
1922–	C. H. Bierman
1932–1934	R. D. Kinsey
1935–	W. H. Keen
1936–	Thomas O. Armstrong
1937–1939	W. H. Keen
1940–1943	Charles H. Simpson, Jr.
1944–1945	Mr. Gohman
1946–1950	George B. Hutchison
1951–1964	Robert L. Capehart
1964–1978	Salvatore D. Gasdia

Commencing in October 1978 a determination was made that the position of director of the facility should be filled by a non-pharmacist civil service supply management officer. Serving as the director since that time have been:

1978–1979	Harry O. Knutson (Acting)
Feb. 1979–Oct. 1979	Thomas W. Miller
Oct. 1979–Sept. 1980	Harry O. Knutson (Acting)
Sept. 1980–Oct. 1980	Wilmer J. Blackwell
Oct. 1980 to date	Vacant

Since the death of the last Director, W. J. Blackwell, in October 1980, the Center has been run by the Deputy Director, Richard A. Moss, a PHS Pharmacist.

Concurrent with the decision that the position of Center Director should be filled by a non-pharmacist supply management officer, the position of Pharmacy Advisor to the Center was created to provide expertise, advice, and guidance on all matters pertaining to Pharmacy. This position has been and is currently filled by pharmacist E. Clifford Brennan since it was created.

Functions:

The PHS Supply Service Center is a full service medical supply depot, providing pharmaceuticals and other medical and dental supplies to approximately 895

Note—I am indebted to E. Clifford Brennan, Pharmacy Director for this special report on the Supply Center, George F. Archambault.

federal medical facilities, including those of the Public Health Service, Indian Health service, Department of Justice, State Department, Coast Guard, Peace Corps, Job Corps, and others.

Since 1950 it has operated a centralized pharmacy service which has as its primary function the packaging of *unit-of-use* dispensing size packages of common use pharmaceuticals. This service has evolved to the point where approximately 1.8 million units are packaged annually in strict accordance with FDA Current Good Manufacturing Practices Regulations.

In addition, the Center provides drug coding, packaging, labeling, and distribution services for a number of large scale government-sponsored clinical trials including the Hypertension Detection and Follow-up Program, the Multiple Risk Factor Intervention-Trials, Beta-Blocker Heart Attack Trials, and the Early Treatment of Diabetic Retinopathy Study.

Continued in May Issue

The Pharmacy and Therapeutics Committee at a monthly meeting of the Baltimore USPHS Hospital. Members, left to right are: James A. Hunter, M.D., chairman; Peter B. Drex, Dental Director; G. K. Massengill, M.D.; Maud I. Larsen, Sr. Nurse Officer; Alvin L. Cain, M.D.; Arthur W. Dodds, Pharmacy Director; Charles G. Spicknall, M.D.; Robert L. Brown, Pharmacy Intern.

LETTERS

Dear Dave:

April 30–May 2, 1982 and November 3–7, 1982 are two sets of important dates!

On April 30–May 2, the American Society of Consultant Pharmacists will hold its 4th Midyear Conference in Nashville, Tennessee at the Hyatt Regency Hotel. This meeting will be held in conjunction with the American College of Apothecaries' Midyear Conference. This will truly be a "noteworthy" event and a unique display of pharmacy unity.

On November 3–7, ASCP will hold its 13th Annual Meeting in New York City at the Sheraton Centre Hotel. This meeting will continue ASCP's tradition of offering high quality continuing education.

As a service to your readers, please print these dates in your publication.

A brochure on the Midyear Conference is enclosed. For more information on either meeting, please feel free to contact me.

Thank you for your assistance.

Sincerely,
R. Tim Webster
Executive Director
American Society of Consulting Pharmacists

ASHP Annual Meeting Offers Expanded Continuing Education Opportunities

WASHINGTON—Combining the annual House of Delegates Session and the opportunity for continuing education, the 39th Annual Meeting of the American Society of Hospital Pharmacists (ASHP), June 6–10, in Baltimore, the meeting offers something for everyone.

In addition to a general session each morning, contributed papers in poster format and several new continuing education sessions are planned. All meeting sessions are to be held at the new Baltimore City Convention Center.

Two clinically oriented features of the Annual Meeting will be "Clinical Grand Rounds" and "Clinical Consultation Sessions." Grand Rounds will combine interesting case reports with discussions of drug therapy, and audience participation will be invited. Clinical Consultation Sessions will be patterned after the Curbside Consultations, so popular at the ASHP's Midyear Clinical Meeting, but will focus on therapeutics solely. Registrants will have an opportunity to discuss therapeutic dilemmas with well-known practitioners in those areas.

"It Works for Me," a new Annual Meeting feature, is designed to be an idea exchange among registrants. Useful forms, manuals, or hints for practice can be shared during this session.

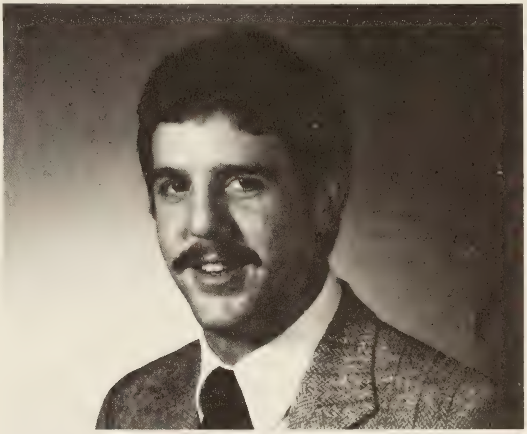
Information on Annual Meeting registration and accommodations is available from ASHP headquarters on request.

Peter P. Lamy, Ph.D., (left) Chairman of the Department of Pharmacy Practice and Administrative Sciences at the School of Pharmacy and Frank B. McGlone, M.D., (right) President of the American Geriatrics Society, were CoChairmen of a special Symposium on "Managing Medication in an Older Population: Physician, Pharmacist and Patient Perspectives." Harriet S. Frieze, (center) is the Director of Professional Marketing for McNeil Consumer Products Company, the sponsor of the Symposium.

Donald O. Fedder, B.S. Pharm, MPH, Assistant Professor in the Department of Pharmacy Practice and Administrative Science was elected Vice-Chairman of the National Council on Drugs. The NCD is an independent, nonprofit body of experts drawn from the academic, industrial, government and public health sectors, dedicated to the improvement of drug therapy. Don, a Past President of the M.Ph.A. has been representing the American Pharmaceutical Association on the NCD since 1976.

In addition, Don was recently elected to serve as Chairman of the Health Care Industry Foundation's Orthotic and Prosthetic Examination Board.

Estelle Cohen, Consumer member of the Maryland Board of Pharmacy appeared on the Symposium program which was held December 9-10, 1981 at the Westbury Hotel in New York City.



David P. Holtwill will serve as sales representative for the Burroughs Wellcome Co. in the Bethesda area of Maryland following an intensive training program. David has a B.S. degree from the Medical College of Virginia School of Pharmacy.

Janis M. Pulcini has been assigned to a Baltimore territory for The Upjohn Company. She recently completed four weeks of training at The Upjohn Company Learning Center in Kalamazoo, Michigan. Janis is a graduate of Temple University.

ABSTRACTS

Excerpted from PHARMACEUTICAL TRENDS, published by the St. Louis College of Pharmacy; Byron A. Barnes, Ph.D., Editor and Leonard L. Naeger, Ph.D., Associate Editor

ACYCLOVIR:

Herpes simplex virus infections are the major cause of death in patients who have received bone marrow transplants. The infections start approximately eight days after the procedure. Acyclovir was administered to 10 patients while another 10 served as controls. Seven of the 10 controls contracted Herpes simplex viral infections while none were seen in the treated group. Acyclovir seems to inhibit viral replication and although it may not eradicate latent infections, it does provide effective prophylaxis against symptoms of reinfection. *N ENG J MED,* Vol. 305, #2, p. 63, 1981.

BAGGIE THERAPY:

Patients with rheumatoid arthritis frequently complain of pain in spite of drug therapy. Heat has been used to help alleviate some pain, but a large group of people seem refractory even to this procedure. Physicians in Philadelphia have resorted to cryotherapy utilizing ice cubes in plastic baggies. In some patients, the use of this technique has led to reduction or complete elimination of drug therapy. The "baggie" therapy was most useful for pain in the knee. *J Am Med Assoc,* Vol. 246, #4, p. 318, 1981.

PREDNISONE:

Large doses of glucocorticoids such as prednisone can cause a loss of nitrogen from the body. This negative nitrogen balance may lead to muscle wasting, osteoporosis, and growth retardation. Nitrogen loss can be minimized by increasing daily caloric intake and by ingesting greater amounts of proteins. *Ann Intern Med,* Vol. 95, #2, p. 158, 1981.

RADIOACTIVE IODINE:

After the accident at Three Mile Island, it became more apparent that a safe method of enhancing the excretion of radioactive I-131 was required. Studies have always indicated that the body is unable to distinguish between various members of the halogen family, e.e. chlorine, iodine, bromine, and fluorine. The renal excretion of radioactive I-131 was shown to be enhanced by ingesting sodium chloride and/or using a diuretic. The best results were obtained in patients who increased their water intake while using both the salt and the diuretic agent. The therapy should be started within two days after exposure to the radioactive material. *J Clin Pharmacol,* Vol. 21, #5, p. 201, 1981

DIABETES MELLITUS:

Vascular complications of diabetes mellitus may be caused by a variety of changes which are seen in patients with this disease. An abnormality has been found to exist which may help explain the increased coagulation of blood which is seen in some people with this condition. A new technique has produced evidence which suggests that erythrocytes adhere to the endothelial cells of the vasculature to a greater degree in diabetics than they do in the same tissue of normal volunteers. Diabetic gangrene and diabetic retinopathy may be partially due to this abnormality. *N Engl J Med,* Vol. 305, #5, p. 237, 1981.

ACETAMINOPHEN:

Animal studies have produced data indicating that acetaminophen is converted in the kidney to para-aminophenol, a potent nephrotoxin. Although it has not yet been determined to what extent this occurs in humans, it may be an explanation which could help explain the renal side-effects association with large doses of the analgesic. *J Pharmacol Exp Ther,* Vol. 218, #1, p. 161, 1981.

DMSO:

Dimethylsulfoxide (DMSO) is an OTC product which is used illegally as a remedy for arthritis. It has been found to inhibit the metabolism of sulindac (Clinoril). Patients using the unapproved analgesic should be cautioned about possible problems which may occur if they use both products. *Am Med News,* Sept. 4, p. 17, 1981.

METHAQUALONE:

Methaqualone is a drug which is highly abused by youthful drug users, but in many cases the tablets sold as methaqualone contain other materials including PCP, diazepam, or a variety of other depressants. Last year the DEA confiscated fewer than 15 tons of illicit methaqualone while over 30 tons have been seized by the agency thus far this year. Much of the drug is imported from the South American country of Columbia. Studies have shown that most drivers who die as a result of a motor vehicle collision and who are under the influence of drugs other than ethanol are under the influence of methaqualone. *J Am Med Assoc,* Vol. 246, #8, p. 813, 1981.

MEPERIDINE:

Meperidine (Demerol) is a widely prescribed analgesic which is metabolized by the liver to normeperidine, a compound with central nervous system stimulating activity. When using the analgesic chronically, it is suggested that it be administered parenterally because a significant amount of the drug will be converted to the metabolite if it is administered orally. Patients with liver dysfunction, including cirrhosis, may convert less meperidine to normeperidine because of decreased function, but they are also more likely to accumulate the metabolite which is formed. Meperidine is best used by the injectable route. *Clin Pharmacol Ther,* Vol. 30, #3, p. 183, 1981.

ACETAMINOPHEN:

Patients using the antineoplastic agent adriamycin were found to experience greater toxicity if they also received the analgesic acetaminophen. Investigators feel that the toxicity may be avoided by carefully timing the administration of the analgesic. More work is being done to learn about the mechanism of this interaction. *Am Med News,* September 4, p. 17, 1981.

LITHIUM:

The effects of the lithium ion on the adrenergic nerve ending was studied using animal tissues. It was noted that the neuronal uptake of norepinephrine is enhanced at therapeutic lithium concentrations thus attenuating the response of the adrenergic nerve ending to electrical stimuli. Toxic concentrations of the ion are capable of inhibiting the activity of the enzyme monoamine oxidase. *J Pharmacol Exp Ther,* Vol. 218, #2, p. 309, 1981.

BONE NECROSIS IN DIVERS:

Aseptic bone necrosis is a condition seen with greater frequency in commercial divers than in the general population. It does not occur in those divers who have remained above depths of 30 meters, but its frequency increases to approximately 22% in those who have descended to 300 meters. Regular radiographic skeletal surveys are recommended for those who fit into the high risk group. *Lancet,* Vol. II, #8243, p. 384, 1981.

MINOXIDIL:

Minoxidil is an effective antihypertensive agent which may produce an increase in cardiac activity. Beta-adrenergic blocking agents such as propranolol (Inderal) can be used to offset these effects, but they may be contraindicated in patients with compromised respiratory function. Investigators have found that clonidine (Catapres) can be used as a substitute for the beta-adrenergic blocking agents thus eliminating the side-effects of these drugs on the respiratory system while still controlling the activity of the heart. *Clin Pharmacol Ther,* Vol. 30, #2, p. 158, 1981.

DIAZEPAM:

The kinetics of diazepam (Valium) have been investigated in both sexes and in various age groups. It has been suggested that the greater potency of the drug in elderly people is partially due to the fact that the drug is highly bound to plasma protein and elderly patients have less protein-binding capacity. In addition it was noted that the volume of distribution of the benzodiazepine derivative was greater in females than in males and the total clearance of the drug was higher in women than in men. *Pharmacology,* Vol. 23, #1, p. 24, 1981.

FLECANIDE:

Flecanide is an orally effective antiarrhythmic agent which has been found to be useful in treating ventricular arrhythmias. The drug is highly effective in most people and was well tolerated. It has a long half-life in the body and thus may be administered less frequently than other agents used for the same indications. The drug is being distributed by Riker Laboratories for investigational use. *N Engl J Med,* Vol. 305, #9, p. 473, 1981.

ACID SECRETION:

Drinking coffee can cause heartburn and gastrointestinal disturbances. In order to determine the role of caffeine on acid secretion and gastrin release, decaffeinated coffee was administered to a group of volunteers. Decaffeinated coffee produced as much acid release as did regular coffee, and thus the authors have concluded that the material responsible for this release is not caffeine. They are not certain exactly what causes the stimulation. *J AM MED A,* Vol. 246, #3, p. 248, 1981.

VERAPAMIL:

The new drug verapamil (Isoptin) has been shown to be effective in terminating paroxysmal supraventricular tachycardia and in reducing ventricular response in patients with atrial fibrillation. The major complaints from patients taking the drug include initial hypotension and bradycardia. Chronic therapy produces constipation, nausea, dizziness, headache and ankle edema. *DRUG THER,* Vol. 11, #7, p. 44, 1981.

ARTHRITIS:

Patients with arthritis were studied to determine the concentration of endorphin in their serum. It was noted that patients with this condition had lower levels of the hormone than did a group of matched controls. Pain is associated with arthritis, and since patients with arthritis have generalized metabolic deficiencies, they may produce less endorphin than normal and thus would experience more pain and inflammation. *J AM MED A,* Vol. 246, #3, p. 203, 1981.

MOXALACTAM:

A new third generation cephalosporin derivative, moxalactam, has been shown to be effective against *Pseudomonas aeruginosa, Hemophilus influenzae,* and anaerobic bacteria such as *Bacteriodes fragilis.* The drug has a half-life similar to that of cefazolin and thus may be administered less frequently than other antibiotics. Several other agents are being investigated. Moxalactam (Moxan) is being manufactured by Eli Lilly and Co. *CLIN PHARM,* Vol. 30, #1, p. 86, 1981.

Part of a continuing series on today's pharmacy

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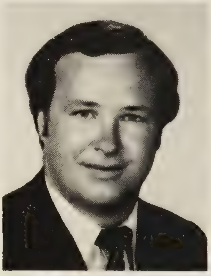
"Almost all patients will have questions about applying the drug regimen to their own schedules. They are willing to modify their daily activities to accommodate a dosage schedule if they understand why the changes are best for them. But these questions can be answered only on an individual basis.

"Handing the patient a full disclosure sheet does not effectively help 'educate.' In fact, a long list of potential adverse effects may even convince a patient *not* to take the medication.

"Every effort must be made not to frighten the patient. Basically, the role of the pharmacist is to help a patient use drugs most effectively and with the least anxiety."

Reprinted from American Pharmacy, Vol. NS 21, No. 7, p. 382

John F. Schlegel, Pharm.D., M.S.
Executive Director
American Association of Colleges of Pharmacy



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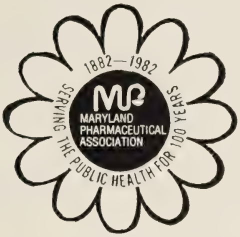
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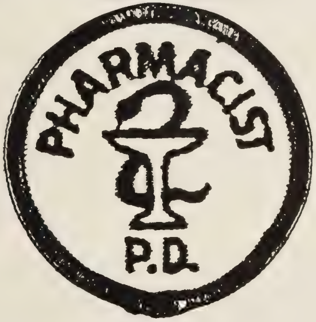

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Spring Regional Pictures

History of USPHS Pharmacy

—George F. Archambalt

Employer—Employee Relations Forum

THE MARYLAND PHARMACIST

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MAY, 1982 VOL. 58 NO. 5

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President's Message

Illegible handwriting of physicians has always been the brunt of jokes, but if you are a pharmacist in a high volume environment, it is not very funny. Poorly written prescription orders cause a variety of ramifications whether you are in a hospital or community practice. First of all, with the number of sound alike drugs increasing, unless the prescription is written legibly, we run the risk of dispensing the wrong drug. Granted, only a small minority of physicians refuse to write out prescription orders neatly, nevertheless, there is no excuse for their cavalier attitude toward handwriting.

Pharmacists should not fill any prescription order where there is any doubt as to what the request is. Where there is any ambiguity, the pharmacist must contact the prescriber. Of course the patient will ultimately suffer from this lack of consideration by physicians.

According to the Board of Pharmacy and representatives of the Division of Drug Control, the biggest problem is with signatures. There is a special problem with hospital prescription orders, where the name of the physician is not printed on the form. Some hospitals have been known to inform their staff that the law provides for a severe fine if their name is not legible. For drug control prescriptions the law is very specific that the name of the prescriber must be stamped, printed or typed. Also, section 187b item 18 at the Maryland Food, Drug and Cosmetic Act prohibits, "prescribing any drug without clearly identifying the name of the prescriber or the prescription form and dispensing any drug based on a prescription form which lacks the name of the prescriber."

The Board of Pharmacy is grappling with the legibility issue, if you have any suggestion to help them get prescribers to write more legibly, *they would appreciate hearing from you.* In the meantime, I have asked the Maryland Hospital Association to inform their members that a problem exists.

Philip H Cogan

Philip H. Cogan,

President

Dedication of Plaque Commemorating 100 Years of Maryland Pharmaceutical Association

Today we honor the memory of two outstanding Marylanders who charted the course of the profession of Pharmacy for many years, David Stewart and William Procter are names nearly forgotten by practicing pharmacists in this time, but they were both central figures in the fledgling profession as it began to take root and grow in the New World, particularly in Baltimore and the surrounding cities and states.

Therefore it is appropriate that we all take a moment to reflect on who these men were and what they did, just as it is necessary for us in the 100th year of the Maryland Pharmaceutical Association to reflect on what we as pharmacists have done.

First, thanks to Professor Ben Allen, we all know more about David Stewart from his excellent article in the February 1982 issue of *the Maryland Pharmacist,* Stewart was 69 years of age when the M.Ph.A. was organized in 1882, so we suspect that he took little part in the actual meetings, although his teaching undoubtedly contributed to the interest of pharmacists in Maryland to organize themselves.

Stewart died in 1899 and by that time had accomplished more than many of us hope to complete in our lifetimes. He was present when the Maryland College of Pharmacy was founded; he was a member of the Board of Examiners; he actively participated in the teaching and was appointed Professor of Pharmacy in 1844, Stewart, being a chemist and pharmacist, had also taken a degree in Medicine two or three months prior to this appointment. Thus, Stewart becomes the first recognized Professor of Pharmacy in the United States. He remained the professor until he resigned in 1846, but continued as Secretary of the College, David Stewart practiced pharmacy in his store at the southeast corner of Hanover and Camden Streets. He was active in civic affairs, being a member of the Baltimore City Council (1835–37), School Commissioner (1936), Ruling Elder in the First Presbyterian Church (1838) and a member of the State Senate (1840).

Stewart was Inspector of Drugs for the Port of Baltimore from 1850 to 1853. In 1853, the Baltimore Pathological Society was formed by Stewart and eight other doctors. His term of office in Annapolis caused him to return there in 1855 as Professor of Chemistry and Nat-

The 1982 Spring Regional meeting was held March 28, 1982, in the Kelly Building. William Skinner (left), Chairman of the Centennial Celebration Committee, presents a plaque honoring David Stewart and William Proctor to Philip Cogan, (right) M.Ph.A. President. The Dedication remarks given by Dr. Skinner are reprinted on this page.

Following the Spring Regional meeting, members and guests posed on the lawn of the Kelly Building next to the new identification sign unveiled at the meeting.

Pictures Courtesy of District-Paramount Photo

The Spring Regional Meeting featured an "Issues Forum" moderated by Speaker of the House Madeline Feinberg. Presentors were: (from left to right) Ronald Telak, Past President of the MSHP; Martin Mintz, Executive Director of the Maryland Chapter of the American Society of Consulting Pharmacists; Bernard Lachman, President of the Maryland Board of Pharmacy; William J. Kinnard, Jr., Dean of the School of Pharmacy; William Grove, President of the MSHP; and Philip Cogan, President of the M.Ph.A.

William Hawk makes a point during the open discussion section of the Issues Forum.

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State Society of Pharmacists
KELLY MEMORIAL BUILDING
B. Olive Cole Museum
Public Tours by Appointment

Board members are shown with the new sign which was a special project of the Centennial Celebration Committee to help alert the public to the availability of the B. Olive Cole Pharmacy Museum.

President Cogan reads a message from the Governor and proclomations from the Maryland House of Delegates and Senate.

ural Philosophy at St. John's College. Stewart returned to Port Penn, Delaware in 1862 and in 1872 the Maryland College of Pharmacy conferred the Doctor of Pharmacy degree on him.

William Procter, Jr. was born in Baltimore as the 9th son of Izak and Rebecca Procter, a Quaker family, in 1817. Procter died in 1874, so he too had little direct participation in the formation of the Maryland Pharmaceutical Association. Procter however gained the appelation of "Father of American Pharmacy" because of the activities of his career. He became dean of the Philadelphia College of Pharmacy in 1865; editor of the American Journal of Pharmacy in 1867; Secretary of American Pharmaceutical Association in 1852; Professor Pharmacy 1846; Editor of Practical Pharmacy in 1849; participated in the 3rd ed (2nd revision) of the U.S.P. and was elected to USP Committee of Revision in 1850.

Time does not permit the listing of all of Procter's activities, suffice it to say that although he left Baltimore at age 14 to learn the apothecary trade, he remained interested in his birthplace and the Pharmacy profession there.

The Maryland College of Pharmacy awarded Procter the Doctor of Pharmacy degree in 1871 on the same occasion that it awarded David Stewart a degree.

Therefore, it is fitting in this 100th year of our association that we take time out of this meeting to reflect on the memory of these two imminent pharmacists from Baltimore, Maryland, and to remember them as men who contributed so that we have today a more useful profession of pharmacy to serve the public health.

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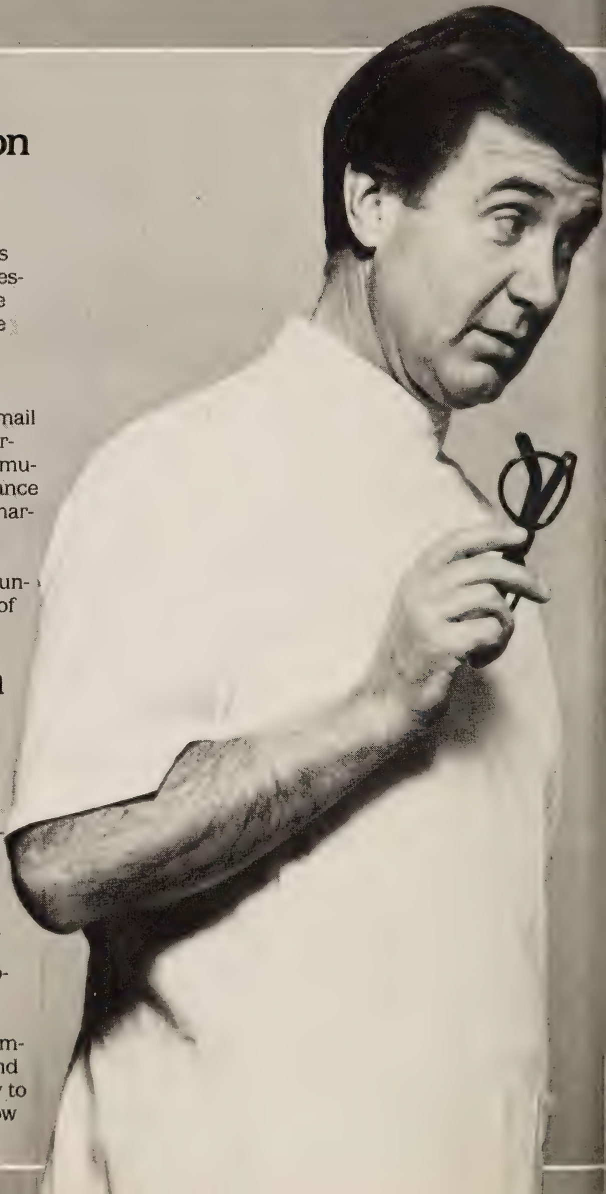

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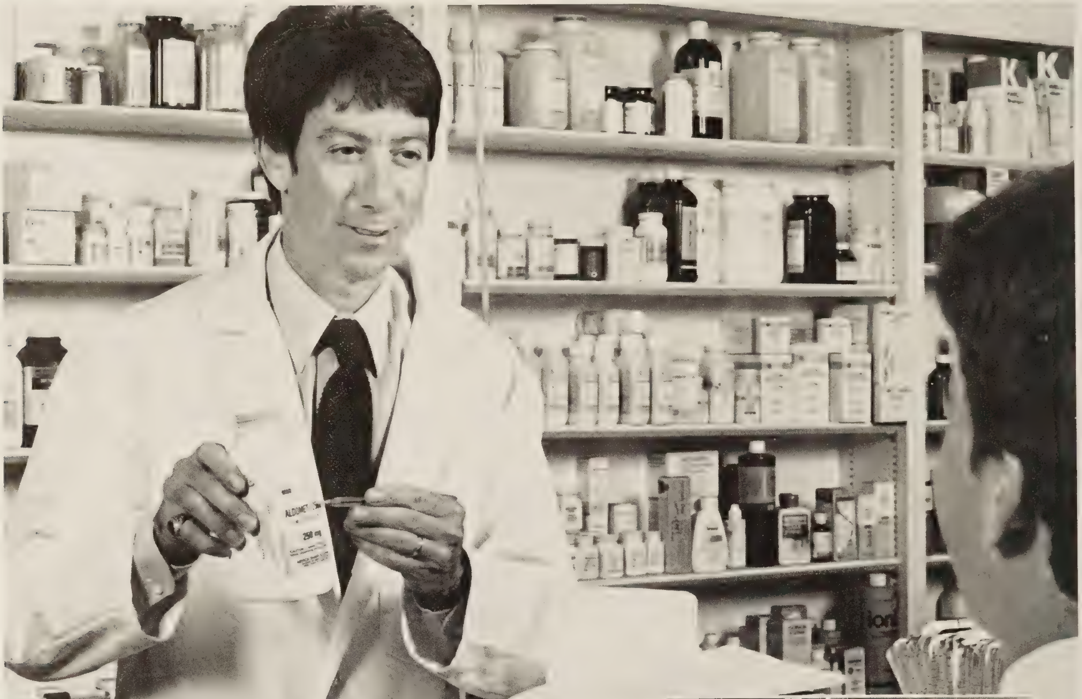

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AD NO. 104-A

EMPLOYEE—EMPLOYER RELATIONS FORUM

The purpose of the Forum is to deal creatively with the issues in Maryland Pharmacy employer and employee relations. This Committee of the Association is made up of individuals from a wide variety of practice settings. We are asking for input on current employment issues from all segments of the profession. The Forum will act as a "sounding board" on these issues and will provide some ombudsman activity.

Suggested Employment Agreement Considerations

The Employer-Employee Relations Forum feels that a clear understanding of the Employment Relationship is necessary to prevent misunderstanding by either the Employer or Employee Pharmacist. The Forum feels an agreement between the Employer and Employee Pharmacist, whether it be an informal agreement or highly structured formal contract, is necessary for a mutually satisfying relationship.

The Forum therefore presents, as a service to the members of the Maryland Pharmaceutical Association, a list of job-related items which should be considered and discussed at the time of employment by the employer and employee pharmacist.

1. *Job Description.* The Pharmacist should have a clear understanding of the duties, responsibilities, and authorities that will be expected as part of the employment. In some cases employer may wish to provide a "Policy Manual" that will outline operating procedures for the employee pharmacist. This will allow both employer and employee to measure performance against an established criteria.

2. *Length of Employment.* In most instances the length of employment will be indefinite. However, the following should be discussed:

   a. Length of the "Probationary Period" if any.
   b. The duration of the agreement, if any.
   c. The conditions under which the agreement may be re-negotiated.

3. *Compensation.* As part of the compensation package, some of the following may be considered:

   a. salary (hourly or weekly)
   b. overtime
   c. Bonus and or profit sharing
   The method of arriving at such a figure should be pre-determined and agreed upon.

4. *Benefits.* Without intending to be all inclusive the following list of possible employment benefits is provided and if available should be clearly understood:

   a. vacation
   b. sick leave
   c. professional society membership
   d. continuing education
   e. health insurance
   f. Life insurance
   g. professional liability insurance
   h. income protection insurance
   i. retirement plan
   j. stock purchase options
   k. personal purchases—employee discounts
   l. professional attire
   m. court time (jury duty, witness)
   n. funeral leave

5. *Schedule.* While allowing for flexibility, an understanding should be reached regarding the general hours to be worked, shifts, and procedures for requesting alterations of the standing schedules. In addition, it is helpful to know specifically which day will be considered holidays.

6. *Practice Limitation.* In some practices an employee may wish to stipulate that the employee pharmacist may not work for another employer in a relief or part-time position.

7. *Arbitration of Disagreements.* It may be helpful to provide a description of the manner in which disagreements can be resolved. The employer-employee relations forum will not serve as a formal arbiter, but is available to make recommendations for arbitration.

8. *Termination.* The agreement may be formal or informal, but the amount of notice (and or severence pay) should be specified.

In conclusion, we cannot emphasize enough the importance of regular, open communication between the employer and employee.

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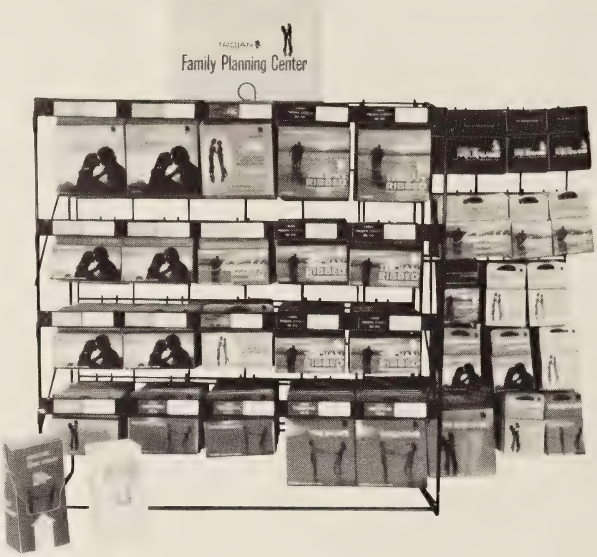

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A Brief History of USPHS Pharmacy in Maryland

George F. Archambalt

Continued from April Issue

PART III

Pharmacy Service, Clinical Center, NIH—Bethesda, MD[4]

History

Back in 1951, there appeared in the January–February issue of the Bulletin of the American Society of Hospital Pharmacists, an article by John C. Trautman, M.D. Director, the Clinical Center, Jack Masur, M.D., Chief of the Bureau of Medical Services, USPHS and George F. Archambault, Ph.C., D.Sc., LL.B., Chief of the Pharmacy Branch, Division of Hospitals of USPHS (Federal Security Agency) PHS, an article entitled "Clinical Center, NIH—Facilities for Pharmaceutical Services." The paper closes with these two (2) paragraphs:

(1) "It is expected that the Clinical Center will be completed in 1952 and patients admitted the early part of 1953. Thus will begin the writing of another chapter in the history of man's attack on the disease groups which constitute major causes of death and disability in the United States. The relationship of physician-pharmacist-patient assumes a special importance when treating and studying patients with long-term illnesses and infectious diseases. The clinical-pharmaceutical research problems that will be encountered in this pharmacy in the allied fields of basic pharmacology, toxicology, posology, pharmacognosy, biochemistry and stochiometry will be varied. These, along with the general problems of hospital pharmacy management and operation will challenge the ingenuity and resourcefulness of skilled hospital pharmacists."

(2) "Acknowledgements. The National Institutes of Health gratefully acknowledge the many contributions of individuals of the pharmacy profession who so willingly served as consultants in the planning and designing of this pharmacy. Special mention should go to Mr. John Murphy, chief pharmacist at the Massachusetts General Hospital in Boston, Mr. Don Francke, chief pharmacist of the University Hospital at the University of Michigan, Ann Arbor, Mr. Arthur Dodds, chief pharmacist of the Lynn General Hospital in Lynn, Massachusetts, Mr. Milton W. Skolaut, chief pharmacist at the U.S. Marine Hospital, Staten Island, and former assistant chief pharmacist at Johns Hopkins, Dean H.C. Newton of the Massachusetts College of Pharmacy, Boston, Mr. Grover C. Bowles, chief pharmacist of the Strong Memorial Hospital at Rochester, New York, Dean E. R. Serles of the College of Pharmacy of the University of Illinois, and Mr. Ernest J. Simnacher, chief pharmacist of the U.S Public Health Service Hospital in Lexington, Kentucky.

A Bit About the Two Directors of the Clinical Center's Pharmacy Service One Serving from 1952 to 1970, the Other 1970 to Date Chief Pharmacist, *Milton Skolaut,* Pharmacy Director Commissioned Officer, USPHS—1952–1970.

Mr. Skolaut entered the Corps in 1949, as chief pharmacist at the PHS Hospital, Staten Island, N.Y.

He received a B.S. in Pharmacy from the University of Texas in 1941, and served his hospital pharmacy internship at The Johns Hopkins Hospital in Baltimore, MD.

Mr. Skolaut became internationally known for his innovations in the development of a complete pharmaceutical service that would meet the needs of a modern research hospital.

Initiates New Services

During his CC career, Mr. Skolaut initiated a service for developing drug dosage forms and suitable assays for many investigational drugs; and a radiopharmaceutical service emphasizing product development in addition to assays and proper controls.

His department was one of the first hospital pharmacies to also offer intravenous additive service round-the-clock.

Other innovations included: pre-packaging drugs and sealing the package to assure reliability; using plastic containers for packaging when practicable, and using lot and batch numbers on labels of all central supply items.

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[4] I am indebted to Dr. Joseph F. Gallelli for much of the material in Part III—Pharmacy Service, Clinical Center, NIH USPHS.—GFA

Also, the Department established guidelines for standards for preparation of I.V. admixtures.

1970 to Date
Chief Pharmacist, *Joseph F. Gallelli*, Ph.D.

Dr. Gallelli joined NIH in 1961 as chief of the CC Pharmacy Department's Pharmaceutical Development Service. Earlier, he had been an investigator with Wyeth Institute for Medical Research in Radnor, Pa., and an instructor at Temple University's School of Pharmacy.

He earned his B.S. degree at Long Island University's Brooklyn College of Pharmacy in 1957, and received his M.S. and Ph.D. degrees from Temple University.

The Clinical Center Today

The Clinical Center today (1981) is a 14-story, 564-bed research hospital located in Bethesda, Maryland. It is part of the National Institutes of Health, the Federal government's primary medical research agency.

The Clinical Center was specially designed to bring scientists working in 1,100 laboratories into close proximity with clinicians caring for patients, so scientists and physicians may collaborate on medical problems.

The primary mission of the Clinical Center is to provide the specialized forms of hospital care necessary for Institute studies.

Patients, upon referral by their physicians, are admitted to clinical studies conducted by NIH Institutes concerned with cancer, allergy, and infectious diseases; arthritis, metabolic and digestive diseases; child health and human development; dental disorders; diseases of the eyes; heart, lung, and blood diseases; neurological and communicative diseases and stroke; and mental and emotional illnesses.

About 15 percent of the patients are "normal volunteers" healthy persons who provide scientists with an index of normal body functions against which to measure the abnormal. Normal volunteers come under such varied sponsorship as colleges, civic organizations, and religious groups.

The Pharmacy Department's Missions and Goals as of 1981

The mission of the Pharmacy Department is to provide comprehensive, properly coordinated, pharmaceutical services of the highest quality to patients and staff of the Clinical Center in support of biomedical research.

To accomplish this mission, the goals are to provide:

1. Effective drug distribution systems and clinical pharmacy services which support quality patient care.
2. Accountable, documented clinical pharmacy practice.
3. Pharmacy education programs which augment clinical pharmacy practices.
4. A pharmacy research program which improves patient care.

The Organizational Set-up of the Pharmacy Services Under Dr. Gallelli

The Pharmacy Department in the Clinical Center consists of the Office of the Chief, Pharmaceutical Procurement and Control Section, Pharmacy Service Section, and the Pharmaceutical Development Service Section. Present staff consists of approximately 65 full-time and part-time employees, 30 of whom are pharmacists.

The Pharmacy Department provides a 24-hour comprehensive pharmacy service both for inpatients and outpatients. The majority of distributive services are provided from the central pharmacy. These include: 1) the purchase of drugs and supplies, 2) narcotic control and distribution, 3) the manufacture of pharmaceutical preparations, 4) a unit dose distribution system for all nursing units, 5) an IV admixture service for all units, and 6) the dispensing of drugs to outpatients.

The Department has an entire section consisting of 11 people for the purpose of assisting physicians in their clinical research. This staff formulates, develops, and assays investigational drugs, performs analysis, sets up blinded studies, and is a national source of investigational drug information. It is analogous to a pharmaceutical manufacturing company that prepares customized investigational drug products for patient use.

The pharmacy provides a clinical pharmacy service, staffed by pharmacists with advanced specialty training. The clinical pharmacists routinely assist physicians in designing and evaluating drug regimens of patients and routinely monitor and assess drug regimens and other patient parameters to assure proper and rational drug therapy. Additionally, staff pharmacists are required to participate in the clinical program through rotations which require daily rounds of assigned nursing units for the purpose of providing discharge counseling, drug therapy consultation, and inservice education.

In order to serve the clinical research needs in drug therapy monitoring, the pharmacy has established a Clinical Pharmacokinetic Research Laboratory and a consultative service. This is a service laboratory for all institutes which determines and monitors drug levels in patients and interprets the response of a patient to a given regimen.

The use of investigational drugs is an important aspect of Clinical Center research. It is the formulation, development, control, assay, dispensing, and clinical monitoring of investigational drugs that differentiate the Clinical Center's programs from all other hospitals in the country.

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PART IV

PHS Pharmacists at FDA in Maryland[5]

It is likely that pharmacists, or at least people who had been trained in pharmacy, were members of the staff of the Food and Drug Administration from its early days, although it is unlikely that one will find few if any listed on the roles with position titles of pharmacist. With the advent of the Civil Service Commission and its classification standard for pharmacists it was economically as well as occupationally very difficult for pharmacists to be identified as such in any kind of Federal service which included non-traditional roles. In other words, if pharmacists were not compounding and dispensing it was unlikely that the job could be classified as a pharmacist position. Later certain kinds of jobs for people who had certain functions related to the evaluation of classification of pharmaceutical products in the marketplace began to be classified in the pharmacy series and a few people began to be hired for their pharmacy knowledge and identified as such. In these instances, however, their grade levels were low because the Civil Service standard for pharmacists did not highly reward pharmacists for their knowledge. The functions of compounding and dispensing required more manipulative than cerebral skills and were not highly paid. Most of the people with pharmacy backgrounds were classified as chemists or food and drug inspectors.

With the incorporation of the Food and Drug Administration into the Public Health Service, and the appointment of Dr. James Goddard as Commissioner in 1966, the Agency saw a substantial influx of young Commissioned Officer Pharmacists who were assigned to the Bureau of Medicine in a variety of positions. Most of these people were "two year" officers; the majority of them either left the service or transferred out of the agency following Dr. Goddard's departure from the Commissionership. A few remained as Commissioned Officers and a few others transferred into the Civil Service, primarily under the Consumer Safety Officer classification. Economically for many of the young officers this was a reasonable move.

Jerome A. Halperin, now Deputy Director of the Bureau of Drugs, told me that when he joined the Bureau in 1974, he did an informal head count of Bureau employees who were trained as pharmacists. At that time he came up with about 125. Included in that total were about a dozen Commissioned Officers, and two or three Civil Service pharmacists, GS-9. The remainder, and by far the bulk of the pharmacists, were classified as consumer safety officers and chemists. A few were classified as pharmacologists and one was a physician. With the exception of the two or three Civil Service pharmacists, there were not jobs that were clearly identified as pharmacy jobs. The Commissioned Officers billet descriptions were quite different. Commissioned Officers fit into a number of programs in the Bureau including the Drug Problem Product Reporting System, the regulations writing group, DESI group, the drug experience group, and the OTC program.

During the 1970's pharmacists began to come "out of the closet" and, in addition, the total number of pharmacists increased. FDA brought on more Commissioned Corps pharmacists for the drug labeling, OTC and drug experience programs, and placed four clinical pharmacists (all with Pharm.D. degrees) in NDE divisions to review DESI drugs. We were aided considerably in this venture by some outside help, primarily from Bill Skinner, a pharmacist-attorney and the American Association of Colleges of Pharmacy who managed to put enough pressure on the Civil Service Commission to get the Commission to express a willingness to allow extension of the current pharmacist standard into higher grade levels by drawing parallels in the kind of work pharmacists do to other kinds of jobs done in the Bureau of Drugs. As a result, several of the Civil Service pharmacists brought on into the labeling program were classified as GS-12 and the four clinical pharmacists were classified as GS-13's.

In the late 1970's the pharmacists began to organize and in 1980 formed a Society of FDA Pharmacists. The Society meets several times per year, usually at noon for "Brown Bag Lunch" meetings. The membership list contains about 150 names including people who are assigned to the Bureaus of Drugs, Radiological Health, Biologics, Medical Devices, Foods, Veterinary Medicine and the Commissioner's Office and EDRO. The broad representation attests to the acceptance of the Society by pharmacists and their willingness to stand up and be counted.

The Consumer Safety Officer classification continues to be the most usual place to find pharmacists; the chemist classification is close behind. The proportion of Commissioned Officers to Civil Service employees has continued to increase. Recently, the Bureau of Drugs has added another half dozen Commissioned pharmacists drawn from the closing of PHS hospitals and clinics. Among the recent pharmacists assigned to FDA is Kent Johnson, Pharmacist Director, Former Chief, Pharmacy Service, USPHS Hospital at New Orleans, who has been appointed the Deputy Director of the Division of Generic Drug Monographs, a position of substantial importance. *—to be continued*

C. Murray Allen, Past President of the Allegany/Garrett Pharmaceutical Association, died of a heart attack in February. He was extremely active in the Local Association and will be missed by his friends and colleagues in Pharmacy.

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[5] The above information was abstracted from a personal letter to G. F. Archambault, December 18, 1981 from Jerome A. Halperin, Deputy Director, Bureau of Drugs, FDA, PHS, HHS.

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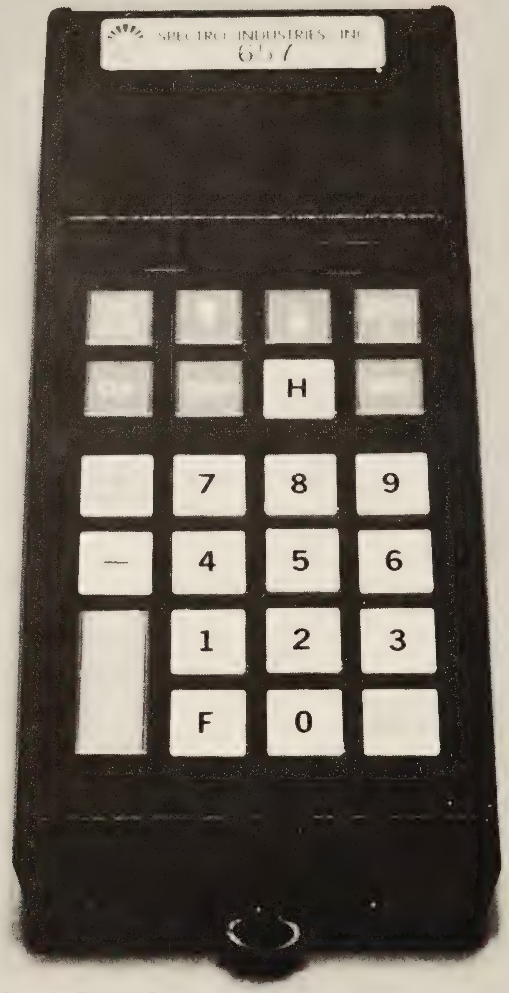

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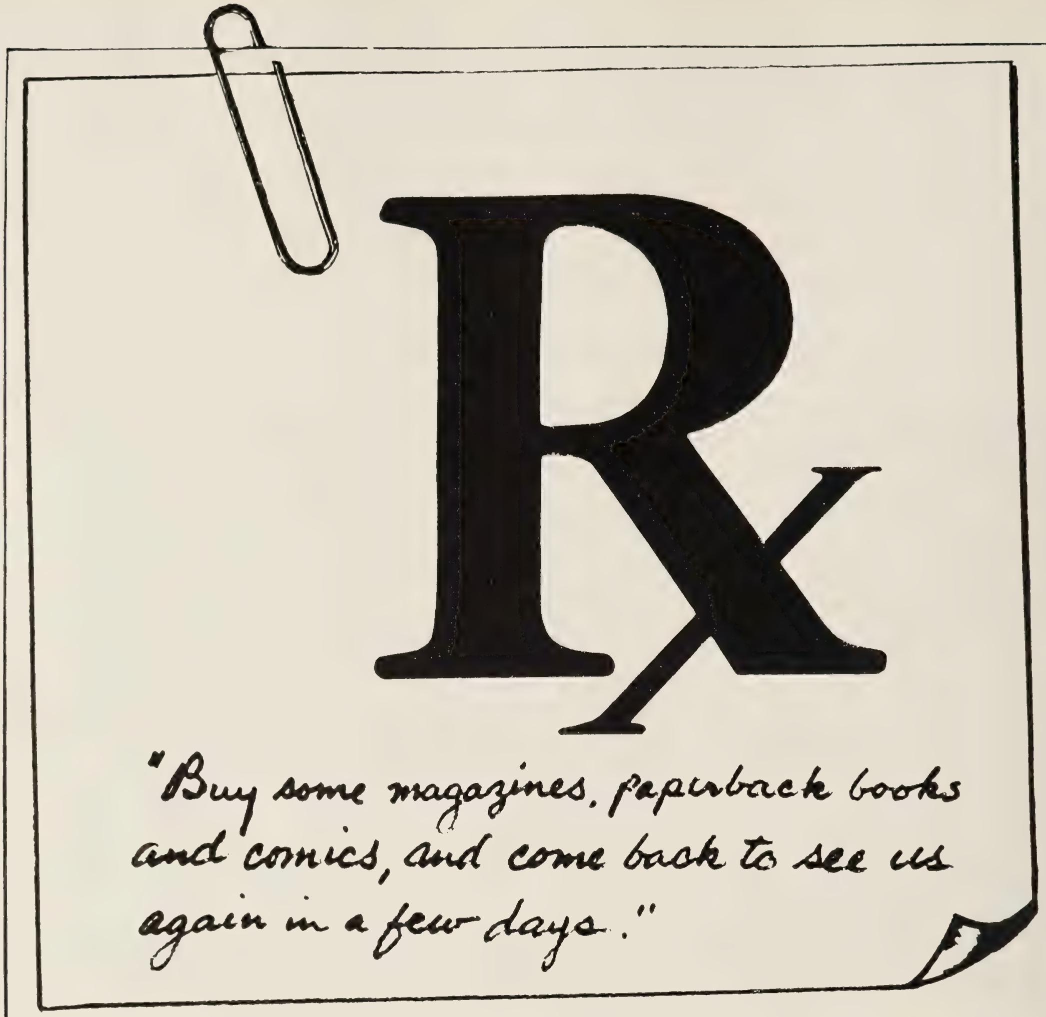
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1. Kirson Medical Equipment Co.	Medical Supplies	10-15-79	04-10-80	PBJ; 2 yrs. prob.; $4,180.10 restit.	H. Grady
2. Donald Kirson	Pharmacist	10-15-79	Acquitted		H. Grady
3. Jerome Kirson	Pharmacist	10-15-79	06-19-80	PBJ; 1 yr. prob.	H. Grady
4. Kirson Drug Co.	Pharmacy	10-15-79	06-19-80	PBJ; 3 yrs. prob.; $500 restit.	H. Grady
5. Arthur Levin	Pharmacist	08-14-80	10-30-80	PBJ 2 yrs. prob.; $76.16 restit. and 500 hrs. pub. service.	E. Bothe
6. Henry Sugarman	Pharmacist	08-12-80	11-12-80	PBJ 2 yrs. prob.; 600 hrs. pub. service.	E. Bothe
7. Leonard Goldberg	Pharmacist	08-12-80	11-12-80	PBJ 2 yrs. prob.; 600 hrs. pub. service.	E. Bothe
8. Harvel, Inc., T/A Hammonds Lane Pharmacy	Pharmacy	12-29-80	02-10-81	$2,500 fine.	J. Hargrove
9. Albert Friedman	Pharmacist	12-29-80	02-10-81	$1,500 fine; $54.90 restit.; 2 yrs. prob.; 200 hrs. pub. service.	J. Hargrove
10. Marian Butler	Pharmacist	12-29-80	02-10-81	$1,000 fine; $61.92 restit.; 2 yrs. prob.; 150 hrs. pub. service.	J. Hargrove
11. The Apothecary Shoppe of Havre de Grace, Inc.	Pharmacy	12-29-80	04-27-81	PBJ; 1 yr. prob.; $8.67 restit.	P. Dorf

PBJ—Probation Before Judgment

* As of March 1, 1982

FDA Warns about Drugs

Recently there has been an increase in media attention to issues surrounding the safety and effectiveness of generic drugs marketed in the United States. A segment aired last month on a national news television program reported on the death of an Ohio woman which was attributed to the ingestion of unapproved generic furosemide tablets obtained in the marketplace and subsequently dispensed on prescription.

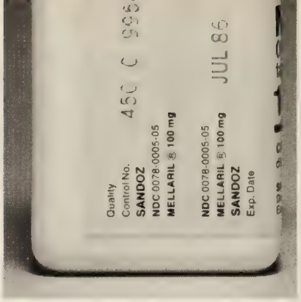
The large increase in the number of generic drugs on the market is the result of several factors. Among these are: 1) expiration of patents on a number of drugs with large market potential, 2) passage of drug substitution laws by State legislatures, and 3) challenges to federal drug laws in a number of legal actions. These and other factors have encouraged firms to enter the market with generic counterparts in a rapid manner, in some instances without the approval of the Food and Drug Administration even though such approval may have been required. We have proceeded with a number of regulatory actions which have resulted in removal of many unapproved drugs from the market. In fact, we believe that no new unapproved generics have entered the marketplace during the past year.

However, we caution pharmacists that there may still be unapproved drugs which entered the market previously that still remain on wholesale and retail shelves. Such products may posses safety and/or effectiveness problems and we encourage pharmacists to examine their stocks. The approval status of marketed drugs as well as their therapeutic equivalence is detailed in *Approved Prescription Drug Products With Therapeutic Equivalence Evaluations* distributed on subscription by the U.S. Government Printing Office. Interested persons may subscribe (at a fee) or call FDA's Bureau of Drugs at (301) 443-1016 to obtain the status of any drug in question.

Should we become aware that unapproved drugs with significant medical implications are again entering the market, we will alert you by one of these advisories.

We would appreciate it if you would give this information the greatest possible circulation among your memberships and patrons. We believe it will answer some questions in the professional community.

Should any questions arise, we will be pleased to provide whatever information is needed. We can be contacted at (301) 443-1016.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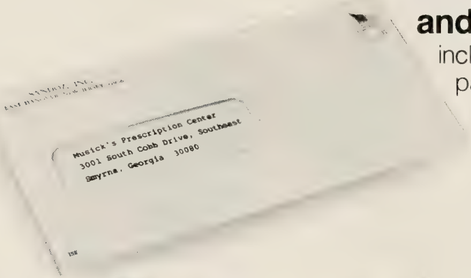
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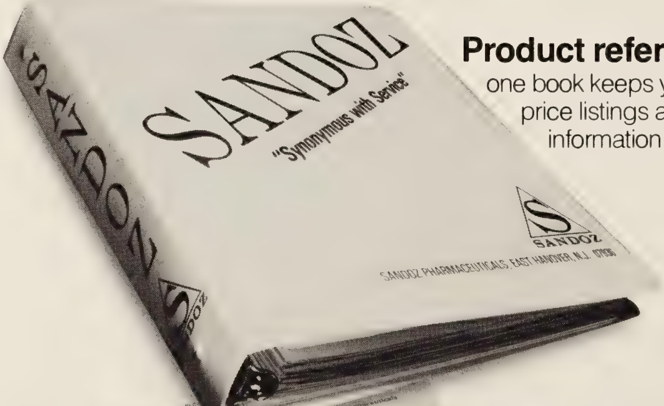
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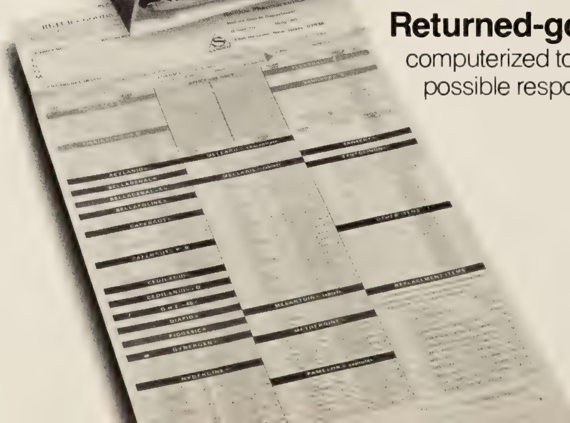

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FDA lists new drugs for 1981

The 27 new drug chemicals, and their trade names and indications, approved in 1981:

Generic Name	Trade Name	Indication
Albuterol	Schering's Proventil	Bronchodilator
Alprazolam	Upjohn's Xanax	Antianxiety
Alprostadil	Upjohn's Prostin VR	Palliative therapy to maintain ductus arteriosus in newborns
Amiloride hydrochloride	Merck's Midamor	Antihypertensive
Atenolol	ICI Americas' Tenormin	Antihypertensive
Bethanidine sulfate	A.H. Robins' Tenathan	Antihypertensive
Buprenorphine	Eaton's Buprenex	Narcotic analgesic
Captopril	Squibb's Capoten	Antihypertensive
Cefotaxime sodium	Hoechst-Roussel's Claforan	Antibiotic
Ceruletide	Adria's Tymtran	Antiulcer
Estramustine phosphate sodium	Hoffman-LaRoche's Emcyt	Antineoplastic
Flunisolide	Syntex's Nasalide	Symptoms of seasonal rhinitis
Gemfibrozil	Warner-Lambert's Lopid	Lipid regulating agent
Halazepam	Schering's Paxipam	Antianxiety agent
Isosulfan Blue	Hirsch Industries' Lymphazurin	Lymphatic contrast agent
Ketoconazole	Janssen's Nizoral	Antifungal (internal)
Mezlocillin	Miles' Mezlin	Antibiotic
Moxalactam disodium	Lilly's Moxam	Antibiotic
Nifedipine	Pfizer's Procardia	for angina
Piperacillin sodium	Lederle's Pipracil	Antibacterial
Saralasin acetate	Norwich-Eaton's Sarenin	Detection of angiotension II-dependent hypertension
Secretin	Kabi Group's Secretin-Kabi	Pancreatic diagnostic
Sucralfate	Marion's Carafate	Anti-ulcer
Sulfadoxine (Pyrimethamine)	Hoffman-LaRoche's Fansidar	Antimalarial
Temazepam	Sandoz's Restoril	For insomnia
Trazodone	Mead Johnson's Desyrel	Antidepressant
Verapamil	Knoll's Isoptin and Searle's Calan	Supraventricular tachyarrythmias

Joint Commission Members Support Uniform Policy on Expiration Dates for Pharmaceutical Products

Members of the Joint Commission on Pharmacy Practitioners have supported uniform semiannual expiration dating in January and July for all prescription drugs. The Commission recognizes the difficulties associated with uniform January and July dating for products with relatively short shelf lives, but will urge manufacturers to use the January and July dates to the extent possible, and especially for those with a shelf life of at least 60 months. Members of the Commission have taken this position to assist pharmacists in inventory control and assure patients' medications are dispensed or returned prior to the expiration dates approved by the Food and Drug Administration.

The Commission contacted pharmaceutical manufacturers during 1981 to determine (1) current expiration data policies, (2) if the firms would consider adopting the policy supported by members of the Commission, and (3) reasons for not adopting this policy. Following an exchange of correspondence with executives of the companies, several manufacturers are reviewing current policies with the expressed hope they will be able to assist practitioners with this important matter. Many manufacturers have already adopted the January and July dating on many of their products.

When was the last time your insurance agent gave you a check . . . that you didn't ask for?

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name

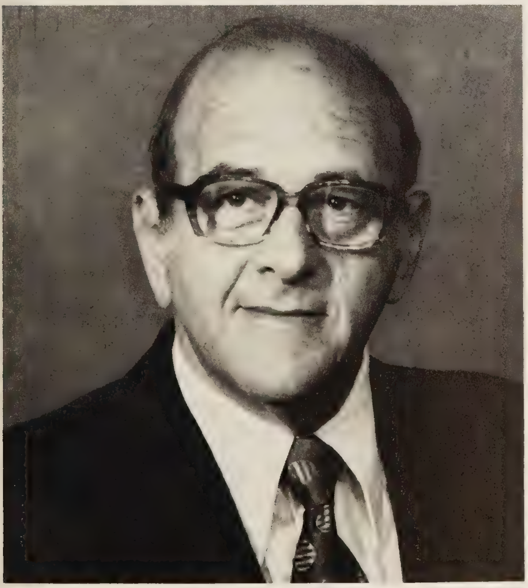
firm

address state zip

telephone #

Melvin Rubin (left) presents David Banta (right) with the award for the Honorary President at the Alumni Association Banquet on March 14, 1982.

The Annual March Dinner meeting of the Alumni Association also heard Dr. John Toll, President of the University of Maryland bring greetings.



Alex Mayer, Pharmacist and partner in the firm of Mayer and Steinberg, has announced his retirement after many years of serving the insurance needs of the pharmacy community.

A featured attraction at the Alumni Banquet was well-known Baltimore Disc Jockey, Johnny Walker. Mr. Walker entertained the audience with his special brand of humor and answered many questions about the broadcast business.

No Alumni function would be complete without the special innvocations of Samuel Goldstein.

Albert Farmer, Chancellor of the UMAB campus greeted the Alumni Association banquet. At this affair he informed Association officers that the Kelly Memorial Building would not be moved or destroyed to make way for University expansion.

The R&D maze is a long and costly road to travel.

Luck does not bring life-saving products to market.... a well planned Research and Development Program does...but, the R&D maze is a long and costly road to travel. Recent studies indicate that it takes as much as 10 years and $70 million to bring a new medicine to market. This year Pfizer will spend over $200,000,000 on R&D in an effort to provide new products that are safe and effective and meet our high standards of quality. Pfizer's R&D commitment today helps to assure better health tomorrow.

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Wendell T. Hill, Jr. Dean of the Howard University School of Pharmacy welcomes Pharmacists to the Continuing Education Coordinating Council's March 14th program held at the Howard University Hospital.

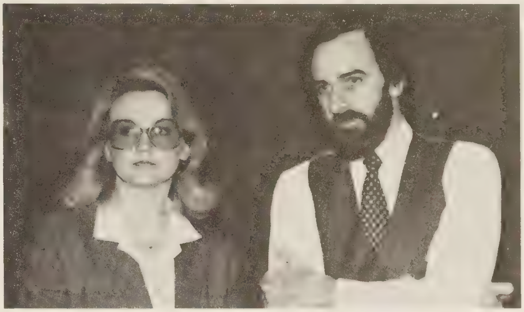
Do Not Block
Stair Exit
ARD UNIVERSITY HOSPITAL

Debora Schaible discussed pediatric drug therapy at the Seminar.

Sumner Yaffe presented an overview of Pediatric therapeutics.

HOWARD UNIVERSITY HOSPITAL

Wendy Klein-Schwartz Chaired the program for the Council and served as Moderator.



Avis J. Erickson (left) presented the topic of drug therapy during Lactation and Gary Cupit (right) discussed treatment of common disorders during pregnancy.

HOWARD UNIVERSITY HOSPITAL

Chris Rodowskas assisted the Council in the planning and the presentation of the program which was the first jointly sponsored C.E. presentation between the Council and the Howard University School of Pharmacy.

Pictures courtesy Abe Bloom — District Photo

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LETTERS

Dear Dave,

Congratulations to you and the Industrial Relations Committee.

For 8 months, I tried unsuccessfully to get Winthrop Labs to honor a return of outdated Rx items. I wrote to them on a number of occasions, but to no avail. I was not even afforded the decency of a reply.

I finally turned to our association for help. You and the Committee presented my complaint to Wintrhop on Feb 23, '82. Lo and behold! by March 10, I received my replacement goods. I just couldn't believe it.

Thanks again for demonstrating the power and usefulness of our organization.

Nathan Schwartz

Dear Mr. Banta:
Subject: Marion's New Prescription Drug Plan

We appreciate the rapid response to my letter of January 18 and would like to bring you up to date with our progress in revising the Marion Prescription Drug Plan. Marion has been busy!

The response we received from pharmacists and pharmaceutical association executives from all over the United States has been very helpful to us in setting the objectives for our plan. Very simply, our objectives are to pay the usual and customary dispensing fee in the amount which a pharmacy usually charges its customers. Simple as that sounds, we discovered that it is not an easy task for third party administrators to handle. Therefore, Marion has set up its own plan, using a third party administrator, Risk Management Council, Inc. of Arkansas. This plan will be effective April 15, 1982.

The method by which our plan will pay usual and customary dispensing fees is pretty straightforward: If one pharmacy determines that its dispensing fee is a percentage of the average wholesale price of the prescription, Marion will reimburse this amount to that pharmacy. On the other hand, if another pharmacy charges an average dispensing fee that is the same for all prescriptions filled, we will reimburse that pharmacy for its dispensing fee, because the amount represents its usual and customary fee.

Other uncommon features of the Marion Prescription Drug Plan are likewise oriented to simplicity. Our plan does not require any type of membership fee or membership agreement for pharmacies to participate. Each plastic identification card carried by a Marion associate includes a plan description on the back of the card, which provides the pharmacist with details of how the plan works and a toll free number to call for questions. Marion's normal procedure will be to reimburse pharmacies within one week of receipt of the universal claim form, unless the pharmacy desires a different time frame.

Marion places a very high priority on its relationship with pharmacists throughout the country. Because of this relationship, we want to assure that our prescription plan treats each pharmacist fairly. We sincerely hope that this new Marion Prescription Drug Plan meets each pharmacist's needs as a third party reimbursement prescription drug plan.

We thank you for your help and would appreciate your passing along information to your members about the new Marion Prescription Drug Plan. Should you have any questions concerning this Plan, please feel free to contact Mr. Gene D. Muhlenpoh, Director of Compensation and Benefits, on our toll free number of (800) 821-3406.

Sincerely yours,
Fred W. Lyons, Jr.

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ABSTRACTS

Excerpted from PHARMACEUTICAL TRENDS, published by the St. Louis College of Pharmacy; Byron A. Barnes, Ph.D., Editor and Leonard L. Naeger, Ph.D., Associate Editor

BARBITURATE WITHDRAWAL:

Twenty-one barbiturate addicts were treated with oral phenobarbital in an attempt to withdraw them from other barbiturates without experiencing symptoms of withdrawal. Intravenously administered phenobarbital has been used in the past, but this is inconvenient and less acceptable to the patient than is oral therapy. This group of addicts received large oral doses of phenobarbital and none developed seizures or other evidence of barbiturate withdrawal. *CLIN PHARM,* Vol. 30, #1, p. 71, 1981.

N-ACETYL PROCAINAMIDE:

Procainamide has been found to be acetylated to produce N-acetyl procainamide, a metabolite with good antiarrhythmic activity. In addition, it appears that the lupuslike reactions seen in patients taking procainamide (Pronestyl) are less likely to occur if the acetylated derivative of the drug is used. Eleven patients who had previously experienced procainamide-induced lupus reactions were given N-acetyl procainamide orally. These patients were able to tolerate the acetylated derivative thus suggesting that the lupus-like reaction is caused by the aromatic amino group on procainamide and that acetylating this site prevents initiation of the adverse reaction. *ANN INT MED,* Vol. 95, #1, p. 18, 1981.

LEVOTHYROXINE PREPARATIONS:

Two brand name products of levothyroxine, Synthroid and Levothroid (formerly Letter) were administered to patients on long-term thyroid replacement therapy. Suitable thyroid function tests were performed to compare the physiological reaction to these formulations. It was found that these two products are not interchangeable, and that patients stabilized on one brand should not be given the other without reevaluation. *J Am Med Assoc,* Vol. 247, #2, p. 203, 1982.

HEART FAILURE:

Patients with severe chronic heart failure are often given hydralazine (Apresoline) to reduce peripheral pressure and decrease the work required of the myocardial muscle. Patients who have been on the drug for long periods of time may develop resistance to the drug and other vasodilators may have to be used to effectively decrease peripheral resistance. *N Engl J Med,* Vol. 306, #2, p. 57, 1982.

RANITIDINE:

Some patients have experienced resistance to the use of the H-2 antagonist, cimetidine (Tagamet), and thus face serious consequences. Three such patients were treated successfully with an experimental agent called ranitidine. The new drug may be most useful in patients who do not respond to conventional therapy. *N Engl J Med,* Vol. 306, #1, p. 20, 1982.

BLOOD TYPES:

An enzyme isolated from green coffee beans may be useful in helping to prevent shortages of human blood. The enzyme, alpha galactosidase, is capable of removing a sugar molecule from the surface of type B cells thus converting them into type O cells. Type O cells are very desirable since they may be infused into anyone without producing hematological incompatibilities. Further work is being conducted to find an enzyme which might convert type A cells into type O cells because approximately 40% of the population have type A cells which only 10% have type B cells. Interconversion of blood cell types may help to alleviate the shortage of human blood. *J Am Med A,* Vol. 247, #1, p. 12, 1982.

PROPRANOLOL-QUINIDINE INTERACTION:

Propranolol (Inderal) has been used successfully to prevent the tachycardia associated with quinidine administration. Additionally, the beta-adrenergic blocking agent has controlled supraventricular arrhythmias which did not respond to quinidine alone. The antiarrhythmic action of propranolol has been the subject of much investigation because the l-isomer of the drug has beta-adrenergic blocking activity while a quinidine-like action is associated with the d-isomer. Since the commercial preparation contains a racemic mixture of the two forms, it was of some interest to find which action was most involved in correcting arrhythmias. Clinicians have noted that some supraventricular arrhythmias respond to a combination of propranolol and quinidine, but not to either drug alone. Experiments using the isomers of propranolol in combination with quinidine indicate that the potentiated response noted when both drugs are used to treat these arrhythmias is due to the beta-adrenergic blocking activity of the propranolol rather than to its quinidine-like effect. *J Pharmacol Exp Ther,* Vol. 219, #3, p. 651, 1981.

SMOKING:

Previous information indicated that smoking caused irreversible changes in the bronchial epithelial lining. Studies conducted in Australia with autopsy specimens indicate that some regeneration of tissue occurs after one stops smoking. Structural recovery is evident to some extent after two years of abstinence. Statistics indicate that the mortality from lung cancer of former smokers becomes identical to that of nonsmokers after the smoker has discontinued the habit for from 10 to 15 years. *Br Med J,* Vol. 283, #6303, p. 1567, 1981.

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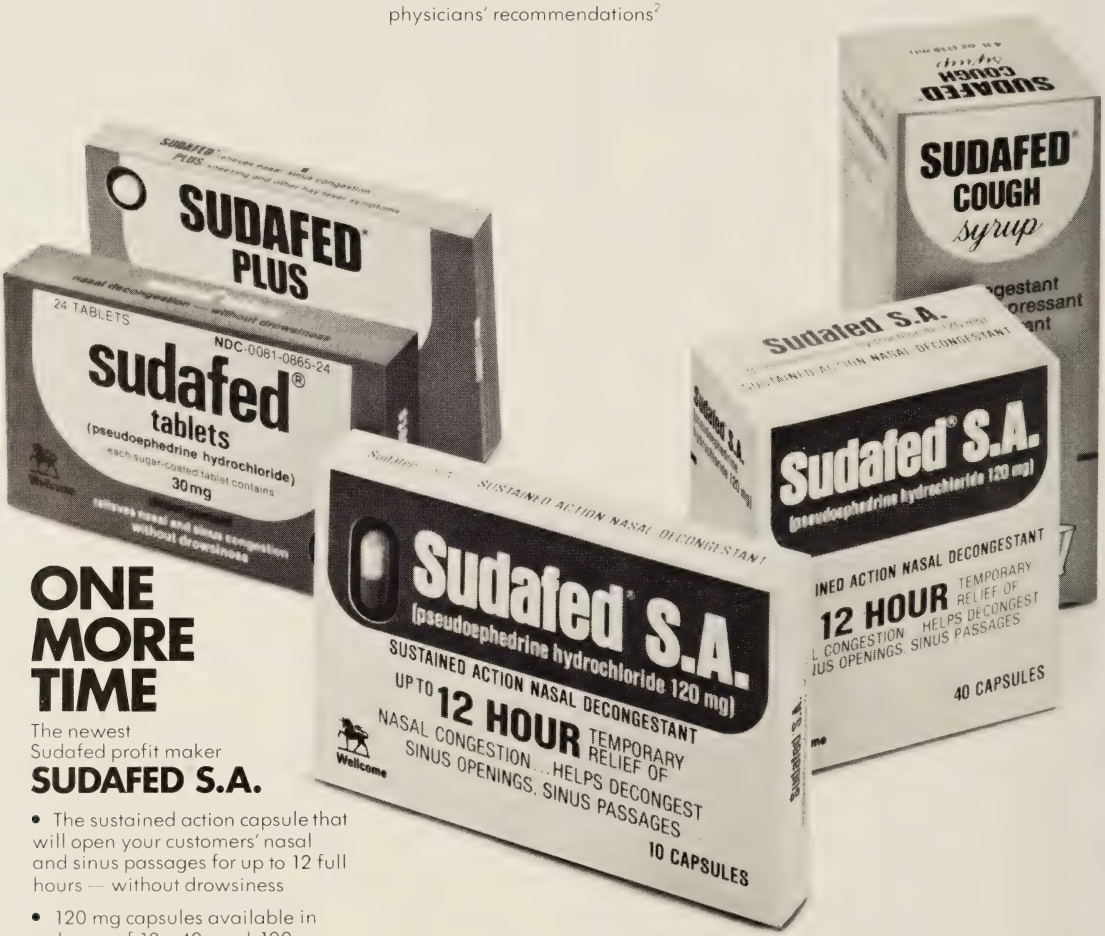
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References: 1. Open Call Survey, *Am Druggist* Sept. 1981. 2. Data on file, Burroughs Wellcome Co.

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Pharmacist Looking for part time work. Call: (301) 526-5666.

PHARMACIST: Opportunity to increase income and explore sales career. Pharmaceutical company selecting Retail and Hospital Pharmacist as part time sales consultants. Send Resume to P.O. K Glasgow, Kentucky 42141

The Maryland Pharmaceutical Association radio show is looking for a few good pharmacists to be interviewed . . . no experience is needed outside of knowledge in any area of Pharmacy, any disease state you are interested in, or in any special interest in the health field you want to talk about. I want the community to hear pharmacists talking about health issues. The format is an interview with me on a subject concerning Pharmacy or health issues. I am an equal opportunity interviewer, I do not discriminate by sex, race, religion, national origin, or area of employment. Please call me, Phill Weiner, at 653-1433

I have felt for some time that Pharmacy needs one of its own to aid in the sale or conversion of existing Pharmacies and in the planning of new ones. Having been involved in these areas for many years for myself, I am now available to my colleagues. I would ultimately like to have a file on those Pharmacists who want to sell and those who want to buy in order to match one to the other. I am also particularly interested in helping Pharmacists change their image from "drugstore" to professional community pharmacy and in just cleaning up their stores. I can be reached most of the time at my Pharmacy. Please call me at 653-1433.

CENTENNIAL MARKET

* Each 1982 member of the Association is receiving a special Centennial membership certificate. These certificates are sent at no additional charge as 1982 dues are paid. Contact the office if you have a question about this certificate.

* Special offer. A Mounting and display kit available from the Association for displaying your Centennial Certificate. $15.00 each from the Association office.

* The M.Ph.A. is offering to the public and its members the USP publication, "About your Medicine." This 400 page reference book covers the top 200 commonly used medicines. $4.50 each plus $1.00 for postage etc. from the Association office. Also available—"About your High Blood Pressure Medicine"—$3.00 each plus $1.00 postage and handling.

* The Pharmacy Art Print "Secundem Artem" is available from the Association office. This 18″ × 24″ full color print is only $25.00 plus $3.00 for shipping and handling.

* Centennial Apothecary Jars with the Association's historic banner displayed is available for only $12.00 each which includes handling. Quantity discounts are available and it makes an excellent gift.

calendar

May 2—CECC Program-Oncology, Quality Inn, Towson (8:45–3:30)
June 6–10—ASHP Annual Meeting, Baltimore
June 18–20—MSHP Annual Seminar, Williamsburg
June 20–24—MPhA CENTENNIAL CELEBRATION CONVENTION—OCEAN CITY RESERVE EARLY—ROOMS ARE LIMITED LARGE CROWD EXPECTED
Nov 4–7—SAPhA Regional Convention, Baltimore
Oct. 10–14—NARD Convention (Boston)

HOTLINE NUMBERS FOR IMPAIRED PROFESSIONALS

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CENTENNIAL CELEBRATION

1882 — 1982
MARYLAND PHARMACEUTICAL ASSOCIATION
SERVING THE PUBLIC HEALTH FOR 100 YEARS

"100TH ANNUAL MEETING"

SCHEDULE

SUNDAY June 20		Registration open at 12:00 Noon (rooms available at 3:00 p.m.) Tennis, Golf, Swimming & Ice Skating Special Commemorative Badges—courtesey SKF—Other special gifts
	9:30 p.m.	*Welcome Cocktail Party*
MONDAY June 21	9:00 a.m. to noon	*"Effective Communications" Harles Cone, Ph.D.*—M.Ph.A. takes Pharmacy's message to the public—Sponsored by Upjohn LAMPA—Brunch, meeting and fashion show
	6:30 p.m.	*Crabfeast and chicken at Berlin Fire Hall* Squaredance
TUESDAY June 22	9:00 a.m. to noon	*Patriotic multi-media celebration of the Centennial*—Lederle Opening General Session—House of Delegates LAMPA Board meeting
	6:00 p.m.	*Cocktail Party—Annual M.Ph.A. Banquet*—Awards— *Special Centennial Address,* William S. Apple, Ph.D., President, American Pharmaceutical Association
WEDNESDAY June 23	9:00 a.m. to noon	*House of Delegates—Second Session* Election of Nominees to State Board of Pharmacy Adoption of Resolutions
	9:00 p.m.	*Cocktail Party* and Presidential reception—Loewy Drug
THURSDAY June 24	9:00 a.m.	*Centennial Humor*—Slide presentation—Morris Cooper, Curator, B. Olive Cole Museum.

William S. Apple, Ph.D., President of the American Pharmaceutical Association, grew up, was educated in, and has spent his working life in the profession of pharmacy.

Dr. Apple is serving his eighth three-year term as the elected chief executive officer of the national professional society, having been elected to the APhA post first in 1959. He served in the APhA Headquarters as Assistant Secretary from 1958 to 1959.

He is a past Vice President of the International Pharmaceutical Federation, a past member of the Board of Directors of the American Association for World Health, Inc., and the U.S. Committee for the World Health Organization. He is past Vice President and served on the Executive Committee of the National Health Council. Dr. Apple is a member of the Committee for National Health Insurance, and an active member of the New York Academy of Sciences. He served five years as President of the American Council on Pharmaceutical Education. He also served as secretary, Vice President, and President of the National Drug Trade Conference.

THE
MARYLAND
PHARMACIST
Official Journal of
The Maryland
Pharmaceutical
Association

June, 1982
VOL. 58
NO. 6

Special
Speaker's Bureau Issue
Featuring Elder-Health outlines

1882 — 1982

Additional copies of this issue of the *Maryland Pharmacist* were made possible through the support of the Warner-Lambert Co.

THE MARYLAND PHARMACIST

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JUNE, 1982 VOL. 58 NO. 6

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President's Message

Recently, a group of pharmacists were asked, "What do you feel are the two most important issues for the success of the profession in the future?" All of the pharmacists agreed that number one was economic survival. It's hard to disagree. With the advent of third parties dictating fees, our economic independence is eroding away. This is an important consideration for all pharmacists, not just pharmacy owners. Remuneration for employee pharmacists is directly linked to the profit and loss statement of their employees. At the same time, I feel the salary for hospital pharmacists is dependent upon the supply and demand for pharmacists in community practice. You can take pride in the MPhA Third Party Committee which is working very hard on your behalf to develop innovative solutions to our dilemmas in the area of third party reimbursements.

There was really no agreement about the second most important issue. One pharmacist stated that leadership at the federal and state level was the next most important issue. Another said overcoming the apathy of the masses of pharmacists was critical. A third talked about unity in the profession and a single voice for all pharmacists. Another said education of the public to appreciate the pharmacist was essential. Another went on about using technicians and becoming more efficient.

An observer noted that these are all important concerns, but can we not see the forest for the trees? Where in the scheme of things does patient care fit as a common goal. All the pharmacists present agreed that patient care was a given. Nevertheless, how often do we reflect on ourselves, our problems and our future? How often do we lose sight of our obligation to serve the patient better? During the centennial year of "Remembering Where We Have Been—Deciding Where We Are Going" let us pay special attention to how we can best serve our patients.

Philip H Cogan

Philip H. Cogan,

President

Elder-Health Partnership in Care

by Peter P. Lamy, PhD. F.A.G.S., Project Director
Madeline Feinberg, Pharmacist, Program Coordinator

developed by: University of Maryland School of Pharmacy
William J. Kinnard, Jr., Ph.D., Dean

ELDER-HEALTH

A program in three parts, aimed at health maintenance/recovery for older adults.

Program Part	Target Audience
Elder-Ed	The Elderly (seniors)
The Caregiver Program	Family (direct caregivers), Significant others, and health care professionals
Provider Interaction	All health care providers, whose cooperation is necessary for health maintenance/recovery

ELDER-ED

A pharmacy-based drug education program for senior adults
SUPPORTED BY: Warner-Lambert Company
Morris Plains, New Jersey

and

The Maryland Pharmaceutical Association
A Centennial Project 1982

INTRODUCTION

The Centennial Celebration Committee of the Maryland Pharmaceutical Association recommended a series of projects for our 100th anniversary. One of the projects is the development of a speakers bureau. A number of accomplishments can result from the speakers bureau. First, it will enable pharmacists to leave their practice settings and build a following by getting out into their communities. Second, it will benefit various audiences, who normally do not have an opportunity to learn about medications and drug regimens. Third, it will enhance the Association's ability to promote our Centenarian with a special service theme.

The Elder-Ed program, developed by the School of Pharmacy, will be the model for the speakers bureau. This program has proved successful and has been met with great acceptance all over the state. The June 1982 issue of the MPhA Journal, thanks to Warner Lambert and Co., contains copies of program outlines that are used for the Elder Ed program. With very minimal modification, they can be geared to other audiences. Copies of this Journal as well as materials from the Maryland Poison Control Center, the Student Committee on Drug Abuse Education (SCODAE) and the U.S. Pharmacopeia will be available at the 1982 MPhA Convention along with special instructions on public speaking. All of these materials, of course, will be available to any MPhA member upon request.

We hope that all pharmacists will attempt to participate in the speakers bureau, at least on a trial basis. It will be a worthwhile and gratifying experience.

Philip H. Cogan, President

ELDER-ED: A CONSUMER DRUG EDUCATION PROGRAM FOR OLDER ADULTS

The primary goal of the Elder-Ed program is to assure that patients understand and respond to a particular therapeutic regimen. Additional goals of the program may be stated as follows:

I. General Goals:

—to assure that the consumer is aware and responsive, one who recognizes that the desired outcome of any health care or specific therapeutic regimen is a shared responsibility between provider(s) and consumer

—to offset some of the undesirable effects of mass media advertising regarding drugs and drug products.

—to recognize (and respond appropriately) to the diminished physical, psychological and economic resources of the elderly, in context with measures and/or medicinal agents recommended.

II. Specific Goals:

—to assure that elderly individuals are knowledgeable regarding their medication regimen

—to assure that individuals understand that they need to ask questions of their physicians and pharmacists and what questions need to be asked.

—to present to older adults facts which argue for the value of preventive care.

—to increase the consumer's awareness of the value of self-medication IF PERFORMED CORRECTLY.

To this end, the Elder-Ed program presents a variety of talks and discussions designed specifically for the older audience. Topics selected have been those requested by the seniors themselves and are most popular with this group. The talks reinforce the specific goals stated above while providing general information on medications commonly used by the elderly.

Health care practices, such as self-medication for example, are discussed throughout each talk. Emphasis is continued throughout all discussions and talks on the ACTIVE role a health care consumer must pursue and the negative aspects of the passive role of the recipient of care.

SELECTED TOPICS OF THE ELDER-ED PROGRAM

The Wise Use of Medications. Your Rights and Responsibilities as a Consumer

This is a general talk, centered around the Elder-Ed publication *You and Your Medicines*. At this, as well as at all other presentations, the publication *Your Personal Medication Record Card*, is distributed. Filling it out can be a service offered at the pharmacy. It is stressed that the Record Card should be carried by the elder and discussed with every prescriber.

Aging and How it Affects Your Response to Medications

This can be the first in a series of talks which follows the "drug" as it travels through the body. It highlights what changes occur as we get older, and why drugs may act differently in older persons.

Generic Drugs, Prescription Drug Prices, and Pharmacy Services

Saving money and the cost of medications are of major concern to seniors. The pamphlet *Everything You Ever Wanted to Know About Generic Drugs*, can be used along with *How to Choose Your Pharmacy/Pharmacist* in presenting this topic. Advantages and disadvantages of using generic medications, cost savings and therapeutic equivalences (bio-inequivalences) are described. Pharmacy services are also discussed with emphasis on how these services contribute to the health of the patient.

How to Select a Non-Prescription Medication

Guidelines for self-medication are covered with emphasis on the role of the pharmacist in selecting a product with the consumer. Special attention is given to cough and cold preparations, analgesics, laxatives and antacids. Pamphlets entitled *Medicines Without Prescriptions*, *Skin Care* and *You and Your Eyes* are available for distribution.

Nutrition and Vitamins for the Older Adult

Principles of good nutrition are emphasized. Some of the current vitamin and mineral fads are discussed and caution is advocated for the elderly. The ElderEd pamphlet *Vitamins Are Not Enough* provides the basis for this topic.

an essential point

NEVER UNDERESTIMATE THE DRUG KNOWLEDGE OR DISEASE KNOWLEDGE OF THE ELDERLY!

Format: Outlines of each topic follow and can be used as a guideline for the speaker. Of course, questions or special audience preference may alter the planned program. Be firm in steering the talk. Set the rules early and request that personal questions be reserved for discussion after the program.

Hints:
—Present the talk in about 20-30 minutes
—Introduce yourself and the topic. Why was the topic chosen and how will it help the elders?
—Be entertaining! Use anecdotes from your own experience or share a joke if appropriate.
—Slides and posters do not hold attention. Darkening the room distracts from attention and slides may have too much glare. Posters are hard to read, especially for the elderly who may have vision impairment.
—Speak slowly and clearly, as elderly may have hearing impairment.
—Elderly are interested in themselves and in their personal experiences. Select examples of drugs with which most are familiar, e.g. aspirin, nitroglycerin, hydrochlorothiazide
—Avoid the term "drug"—use "medication"
—Leave plenty of time after program for questions (even after question period). Be ready to ask questions to break the ice.

SETTING UP AN ELDER-ED TALK IN THE COMMUNITY

Whom to Contact:
—recreation or program directors of local senior groups
—mention to customers
—post signs at prescription counter that pharmacist is available to speak to senior groups
—place ad in local papers
—Area Agencies on Aging
—senior retirement centers

Assuring a Good Turnout:
—give sufficient notice (one month at least) allows people to make plans
—ask director of program to announce in Center newsletter
—Request that announcement be made one week prior to talk as reminder

Doing your own publicity
—post notice in pharmacy window (large letters, bright colors)
—ask local merchants to post notice
—ask local radio station to make public service announcement

Sites to Contact: Where we've been
churches & synagogues
retirement communities
senior citizen housing
public library
local hospitals
social service agencies
Foster Grandparents Program
Senior Companion Program
county commissions on aging
Area Agency on Aging
county and city recreation programs
nursing homes (staff & families)
political groups (e.g. Gray Panthers)
senior organizations (e.g. A.A.R.P.)
eating together sites
senior day care programs

Health Fairs—some guidelines for participation
—insist that pharmacist be responsible for medication screening at registration desk
—give participants their own *Personal Medication Record Card*
—be sure medication history is taken prior to hypertension screening, glaucoma screening, diabetes screening, others

—if you identify problem with medication, be certain adequate follow-up service is provided through the Health Fair Site director.

Suggested Group Size: the audience size can vary from 5 persons to 500

—get approximate size from director or coordinator so that you have sufficient materials

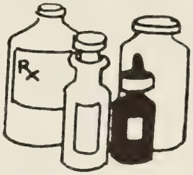
Where to Get Pamphlets for Distribution: contact

Elder-Ed Program
School of Pharmacy
University of Maryland at Baltimore
20 North Pine Street
Baltimore, Maryland 21201

YOU AND YOUR MEDICINES: YOUR RIGHTS AND RESPONSIBILITIES AS A CONSUMER

I. Introduction

1. Introduce self
2. Involve the audience:
    - —how many people here take at least one medication a day?
    - —more than one medication?
    - —how many people take a vitamin every day?
    - —how many drink coffee, smoke cigarettes, drink alcohol?



II. What is a drug (medication)

1. Define
2. What is the "therapeutic" effect of a medication (ask the audience to participate)
    e.g., aspirin:
    - relief of pain
    - reduces fever
    - reduces inflammation
    - prolongs clotting time (anti-platelet effects)
        (be familiar with latest information especially since elderly have misconceptions about this)
3. What are side effects, or unwanted effects with aspirin (solicit responses from audience)
    - stomach irritation
    - bleeding (may be painless)
    - rash
    - anticoagulant effect
4. If dose of aspirin is too high, what are toxic symptoms?
    - ringing in the ears (can elderly "hear" this)

Emphasize: *All medications have some side effects associated with their use. When taking a medication, we want to maximize the benefits of the drug, and minimize the side effects.*

III. Why are the elderly more at risk for the unwanted (or side effects) of medications?

1. They tend to take more medications (risk of drug interactions is greater)
2. A drug given for one disease may worsen a preexisting disease
3. Elderly may take medications incorrectly
    - —cannot read the label
    - —cannot afford medication, so they take it less often
    - —people living alone tend to make more medication errors

IV. How can you, the consumer, get the most benefit from your medications, and expose yourself to the least risks?

Refer to pamphlet *You and Your Medicines:*
The educated consumer will be a healthier consumer!

1. The Visit to the doctor:
    - —what to tell the doctor
    - —what to bring to the doctor (medications, or Record Card)
    - —what to ask the doctor

V. **Personal medication record card—display, explain how to use it.**
- —list prescription medications
  - what they are used for
  - dose
  - how often
- —list non-prescription medications (also products obtained through health food stores)

1. Advantages of keeping *your Personal Medication Record Card*
   - —show to ALL doctors (and pharmacists) you may visit
   - —avoids duplication of medication (e.g. propranolol and Inderal®)
   - —enables monitoring for drug interactions when reviewed by the pharmacist or physician

VI. **Choosing a pharmacy . . . Getting the prescription filled**

1. How to select a pharmacy. Ask audience what they look for when choosing a pharmacy
2. What you should expect from your pharmacy/pharmacist
   - —how to take the medication
     Ask: What does three times a day mean?
   - —What does "empty stomach" mean
   - —Stress importance of taking medicine with plenty of fluids
   - —safety vials
   - —expiration dates
   - —mixing medications
   - —sharing medications
   - —alcohol and medications.

VII. **Questions**

Old Mother Hubbard . . .

Old Mother Hubbard went to the cupboard
to get her poor stomach a pill.
But when she got there,
she found bottles to spare,
from other times that she'd been ill.

There were capsules, and potions,
and drugs for emotions
prescribed by a dozen physicians
Some were her brother's
some she'd borrowed from others
who had almost the same conditions.

"I'll throw it all out,"
she said with a shout
"My doctor's advice I will follow.
And take only those pills
prescribed for my ills,
and use my head before I swallow."

THE AGING PROCESS: AND HOW IT CAN AFFECT YOUR RESPONSE TO MEDICATIONS

I. Introduction

1. Introduce self and tell about the program
2. Aging: a normal process, not a disease process
   a process of change
3. How we change:
   - —do we still run 3 blocks to catch a bus?
   - —do we eat like we did when we were 20?
   - —do we sleep 8 hours a night as we did in our youth?
4. These normal changes may also affect the way medications act in our bodies:
   - —drugs are tested in young people (under 40)
   - —elderly may react differently
   - —pediatrics has become a specialized branch of medicine
   - —with increase knowledge about the elderly, geriatrics may also become a recognized specialty
5. Why are the elderly at greater risk: THIS WILL BE DISCUSSED AS WE FOLLOW A MEDICATION ON ITS TRIP THROUGH THE BODY.

II. **A trip through the body:**

Purpose:
To make you aware of what is happening when you take a medication
To help you avoid some unnecessary side effects

To help you determine if you may be experiencing side effects and what you should do about it

III. Swallowing the tablet:

1. Difficulty in swallowing
   - —due to dry mouth (normal in older persons, or may be caused by other medications, e.g. antidepressants, antispasmodics, etc.)
   - —how to deal with this problem:
     crushing tablets (check with pharmacists. Some must not be crushed)
     opening capsules (newer capsules may be sealed, check with pharmacist)
2. Dentures—may interfere with chewable tablets and can be irritating

IV. Absorption—tablet goes to stomach where it begins to dissolve so that it can be absorbed into blood stream

(some medications, e.g., antacids, are not absorbed, but work in stomach; laxatives are not absorbed but work in small and/or large intestine.)

1. Avoiding stomach upset (one of the major side effects of medication)
   - —take with plenty of liquids (check with pharmacist which liquids cannot be taken with medication)
   - —adequate liquids are IMPORTANT in general. Elderly tend to become dehydrated (often, they do not feel thirst and forget to drink; or they may avoid fluids)
   - —discuss what "take on an empty stomach" means
   - —discuss why some medications should be taken with food or milk
   - —discuss why some products are buffered (e.g., helps aspirin to dissolve more quickly)
   - —discuss why some products are coated (e.g., Ecotrin®) and how this affects drug action (e.g. delayed therapeutic effect)

V. Distribution of drug to tissues of body

Once medication is absorbed into blood stream, it is carried to all tissues of body

Factors which determine medication distribution to body tissues:

- —Cardiovascular function: may be diminished in older people. Therefore, may take longer for medication effect
- —Changes in body composition with aging: as we age, there is likely to be a decrease in muscle tissue and an increase in "fatty" tissue. This can affect how the drug is stored in the body and how well the medication will work.

VI. Blood Levels: (therapeutic and toxic levels)

In order for a medication to work, you need to have a certain amount of drug present in the body. Think of a sink:

In order to get the sink half full, you need to add a certain amount of water. If the drain is open, we need to add enough water to fill the sink as it empties from the drain. On the other hand, if the drain does not empty well, water builds up and the sink overflows.

Think of the body as a sink. Think of the drug as the water going in. When the drug does not get out of the body as fast as you put it in, you begin to see more side effects (or toxicities) of the medication.

Other factors may also be involved in how fast the drug is absorbed into the body, then eliminated. Cardiovascular function, the presence of other diseases, diet and nutrition, exercise and activity levels and also whether or not you are taking other medications at the same time can affect this process.

VII. Metabolism

The drain of the sink is the liver and kidney, which are the two major body organs that eliminate drugs. These organs metabolize or eliminate the drug substance.

The liver performs over 5000 chemical reactions. Chemical change usually makes the drug more water soluble so that it can be eliminated. In some instances, the water soluble metabolite is inactive (will not have a drug effect in the body), but in other instances, the metabolite will also be active. Then the drug action may last longer (and you do not have to take as many doses to get the effect of the drug.)

The kidney eliminates many medications from the body in the urine. If kidney function is significantly slower, this may affect how quickly the drug is eliminated

VIII. Questions you should be asking to determine whether your medication is having the desired effect:

1. Questions to ask the doctor
   - —How can I expect to feel when I begin taking this medication?
   - —What is it for, and how long will I have to take it?

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Jenkintown, PA. 19046
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—Can I expect any side effects?
—What special precautions should I take when I use this medicine?

Some common side effects of medications (ask audience to participate)

- tiredness
- dizziness
- constipation
- upset stomach
- sleep-changes
- diarrhea & incontinence
- blurred vision
- mood changes
- rashes

2. What should you do if you suspect the drug is not working right?
   The pharmacist is the medication expert. He can tell you if the problem is serious and can suggest solutions.

IX. Conclusion:

The purpose of a drug: it is not to adversely affect a patient's physical, physiological, mental, nutritional and health status. Most importantly, drugs should not diminish a patient's already diminished quality of life.

REMEMBER: Drug response of the elderly is much more unpredictable than it is in younger persons.
Always expect the unexpected.
Ask questions. Demand answers.

GENERIC DRUGS, PRESCRIPTION DRUG PRICES AND PHARMACY SERVICES

I. Introduction

1. Introduce self
   (involve audience, invite participation)
2. What is the most important thing you look for when you choose a pharmacy
   - —price?
   - —service?
   - —convenience?
3. Purpose of talk:
   - —to discuss prescription drug prices . . . going up (but not as high as other goods and services)
   - —saving money with generic drugs (can you? should you?)
   - —pharmacy services—what you are "buying" when you pay for your prescription

PART 1. GENERIC DRUGS

I. What is a generic drug? (use pamphlet *Everything You Ever Wanted to Know About Generic Drugs*)

1. Every drug has more than one name
   - —chemical name
   - —generic name
   - —brand name (give examples)
2. Drug patents: exclusive marketing rights for 17 years
   - —to defray costs of research and development of drug
   - —to cover testing of drug before it reaches the market
   - —to cover advertising costs of product

II. Are generic drugs as good as the brand name? Are they the same?

1. A generic drug can be substituted for the brand name when:
   - —the drug (i.e. active ingredient) is exactly the same, and
   - —the medicine has the same effect in the body as the brand name, and
   - —if it has the F.D.A. approval
2. Sometimes the generic drug looks different from the brand name:
   - —the color may be different
   - —the size and/or shape may be different
   - —it may look the same but have slightly different markings

   But, when your pharmacist substitutes the generic product for the brand name, it must satisfy the 3 conditions (above)

III. **What should you do if you get a medicine which is different than your usual medication?**

1. Do not take anything which looks different from your usual prescription medication without checking with the pharmacist:
   - —most pharmacists will notify you if they have dispensed the generic medication and will point out the different name on the label
   - —each state may have different laws regarding generic product substitution. Some states may require that the pharmacist obtain the doctor's permission first. Others encourage the pharmacist to substitute the equivalent drug and to notify the patient. Check with your pharmacist.

IV. **How can you get a generic drug?**

—ask your doctor to prescribe a generic drug
—ask your pharmacist to dispense the generic drug

V. **How does my pharmacist know if a generic drug is as good as the drug I am already taking.**

1. Your pharmacist is the drug expert. He knows what drugs may and may not be substituted
2. The pharmacist you trust will only buy his generic drugs from a reputable manufacturer
3. Many large, well-known manufacturers now make generic drugs. For example Lederle, Parke-Davis, Smith, Kline & French manufacture many generic drugs.
4. Most important, the government must approve the generic drug before your pharmacist can purchase it. Many states now use a formulary system which lists only those manufacturers of approved generics

VI. **Why do some doctors refuse to allow their patients to have a generic drug?**

—some prefer only the brand name because they have had good experience with it and do not wish to change

VII. **Why do some pharmacies have mostly generic drugs, while other pharmacies have a small selection of generic drugs?**

—many high-volume prescription stores carry mostly generics whenever they can and offer a good price. In many cases, they may not even carry the brand name in stock

—many smaller pharmacies may not carry a large inventory of generics (which duplicate the brand name), but instead, may have a larger variety of medicines— especially the less commonly prescribed medicines.

VIII. **Can you really save 50% with generic drugs?**

—as a rule, probably not. You can same money. Shop around. Use the telephone. Ask how much it will cost to have your prescription filled. Be sure you know:
—name of the medication
—strength
—quantity

PART 2. PRESCRIPTION DRUG PRICES

I. **Introduction**

We all agree that prescription prices (and those of patent medicines as well) seem to be increasing all the time. It is true that the manufacturers have been raising prices several times during past years. However, prescription prices have not risen as fast as most goods and services listed on the Consumer Price Index.

Further, although it may seem that you are paying a lot of money for your medication, we suggest you figure out how much it costs for each day's worth of medication.

e.g. 100 tablets @ 20.00 (taking 2 tablets daily) costs 40¢ per day for medication.

II. **How pharmacists price their medications**

—cost plus fee
—percent markup
—loss leaders

Loss leaders may be much cheaper for selected popular medicines, but may be more expensive for less commonly prescribed products.

III. **Other ways to save money**

1. It's cheaper by the 100's
2. But, always ask for a small quantity when starting a new medicine. It may not be right for you. If you do well on the medicine, ask the doctor to give you refills in quantities of 100. (This does not apply for all medications, such as tranquilizers or sleeping preparations.)
3. Ask for senior citizen discount

PART 3. PHARMACY SERVICES

(refer to phamphlet *How to Choose Your Pharmacy/Pharmacist*)

I. **Special pharmacy services**

1. Patient profiles
    —some states require by law
    —explain what they are, how they are used
    —explain how patient should use profiles
        shop at one pharmacy
        ask pharmacist to list your non-prescription medicines too
        ask pharmacist to help you keep your *Personal Medication Record Card* (available through Elder-Ed) up-to-date
2. Other (let audience lead discussion)
    delivery
    how long to fill the prescription

AND REMEMBER . . . If your pharmacist does not speak to you, it is your fault. If the pharmacist refuses to discuss your medications with you, take your business elsewhere!

SELECTING AN OVER-THE-COUNTER (NON-PRESCRIPTION) MEDICATION

(use pamphlet *Medicines Without Prescriptions*)

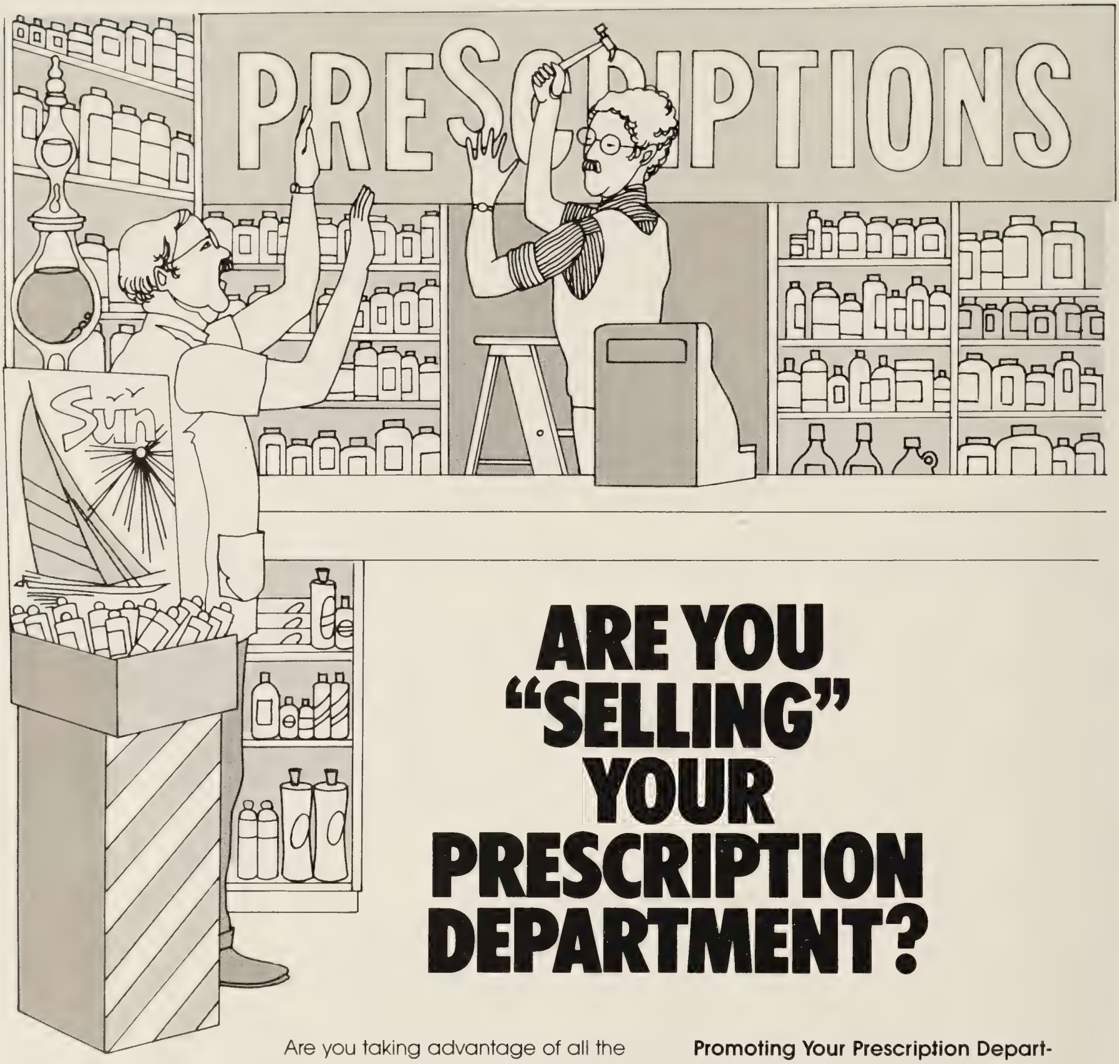
I. **Introduction**

1. Introduce self
2. OTCs—medicines you can buy without a prescription
    —are they safe to use?
    —do they really work?
    —can they interact with prescription medicines?
3. When to consider using an OTC?
    —for minor ailments
    —for short periods of time

II. **Guidelines for selecting a product**

1. Diagnosing what is wrong
    —experienced symptoms previously?
    —minor or severe problem?
    —pain or other limiting factors?
    —asking friends and neighbors
2. Once we diagnose the problem, do we need a medication?
    e.g. treating the common cold:
        with medication, it lasts seven days; without medication, it lasts a week. But medicine may make you more comfortable. It may provide some relief of symptoms
3. OTCs are:
    —medicines that *do* work
    —medicines that *can* interact with other medicines
    —medicines that *can* make certain conditions you have worse:
        e.g. aspirin and ulcer
            antihistamine and prostate

4. Problems with some OTC medications:
    —alcohol content
    —salt content
    —sugar content
    —hidden ingredients
5. Using the pharmacist to help in product selection: You should
    —know what prescription medications you are taking
    —know what other non-prescription medications you are taking
    —know your medical history (problems you have had, including allergies)
6. Guidelines for selecting products of 4 major classes of OTCs used by older people.
    Analgesics
    Cough and Cold Preparations
    Laxatives
    Antacids



ARE YOU "SELLING" YOUR PRESCRIPTION DEPARTMENT?

Are you taking advantage of all the proven methods to promote a pharmacy's prescription department?

If not, SK&F's newest 30-minute videotape program can start you thinking about the opportunities you may be missing.

Our new management program is called **Promoting Your Prescription Department**—and it's designed as a seminar for interested groups of community pharmacists.

You can learn more about advertising, promotional budgets, personal selling, publicity, pharmacy layout, and evaluation of your promotion efforts.

Promoting Your Prescription Department is one more valuable addition to the pharmacy management series now available from SK&F.

Ask your SK&F Representative how you can obtain this videotape program for your next meeting.

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PART 1. OTC ANALGESICS—PAIN RELIEVERS

I. Making a diagnosis: what is causing the pain?
(emphasize) Aches and pains are not a normal accompaniment of aging. Pain is due to injury or disease.

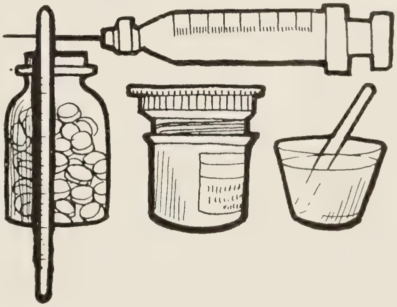
II. Two major choices: aspirin or acetaminophen (Tylenol®)

A. Aspirin (hint: elicit audience participation in discussion)

1. List therapeutic uses:
   —relief of pain of headache, joint pain, toothache, etc.
   —reduces fever
   —reduces inflammation
   (also thins blood; may cause sedation for some)
2. List common side effects:
   —stomach irritation (pain)
   —bleeding (may be painless—black stool)
   —rash or other allergic reaction
   —use particular care with asthma patients
3. How to take aspirin correctly: full glass of liquid: list Do's and Don'ts
   When you may have to avoid aspirin:
   —gout
   —taking an anticoagulant (e.g. Coumadin®)
   —history of ulcers
   —taking other medications for arthritis
   —history of allergies
4. Kinds of aspirin available:
   —plain (brand name or generic)—most important: FRESH!
   —buffered (Bufferin®, Ascriptin®)
   —liquid (Alka Seltzer®, watch sodium)
   —coated (Ecotrin®)
   —with other ingredients (caffeine, antihistamine, other)

5. Hidden aspirin:
   —in cough and cold preparations
   —in many prescription medications (Fiorinal®, Equagesic®)
6. Storage: avoid moisture and heat (medicine cabinet)
   —stale aspirin (odor, crystal formation) dangerous to take

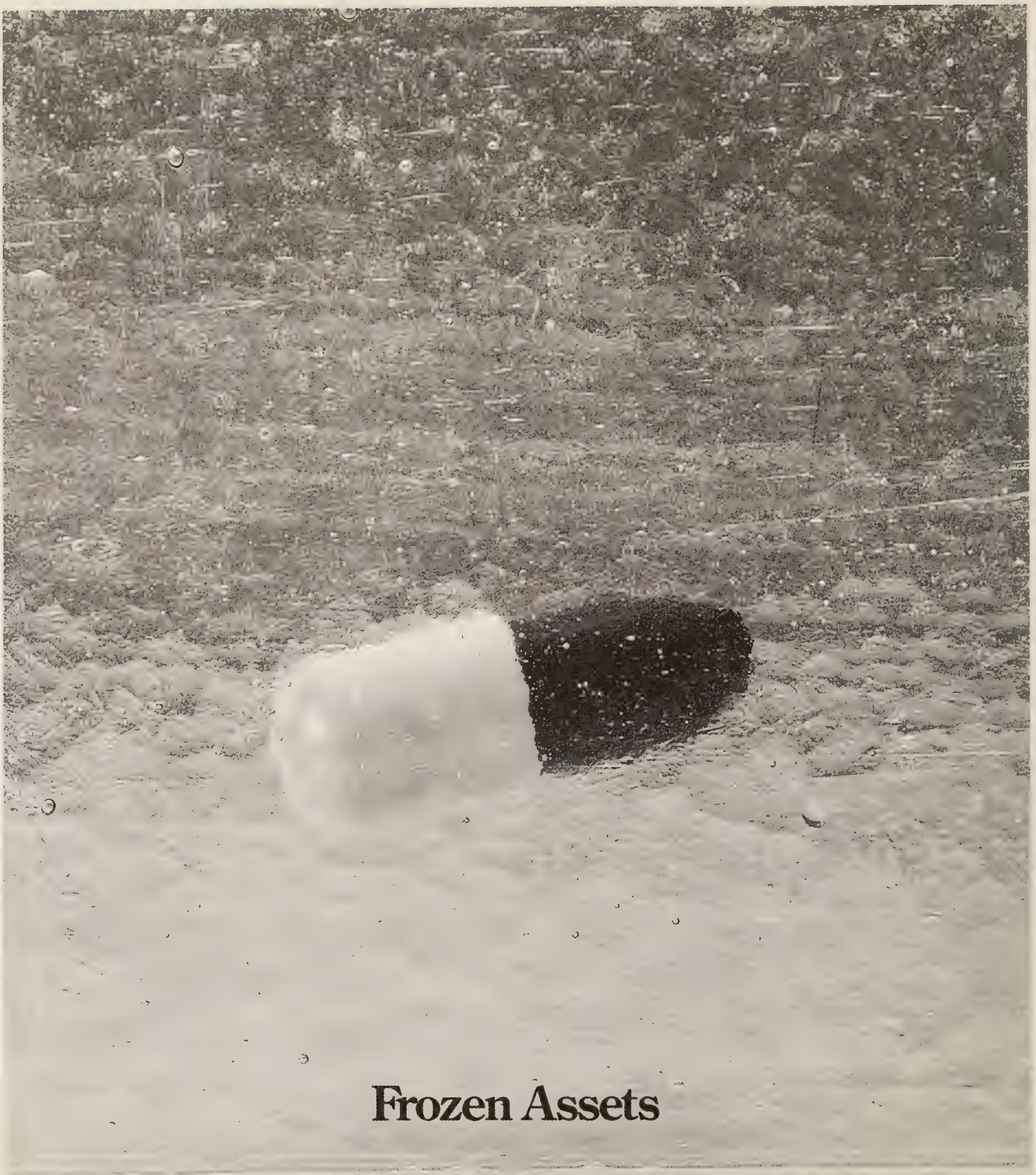
B. Acetaminophen



1. List therapeutic uses:
   —relief of pain
   —reduces fever
2. List side effects associated with use:
   —none at normal doses (some controversy)
3. When to avoid:
   —does not interact with most medications
4. Kinds of acetaminophen available
   —generic
   —liquid form for children and adults
   —regular and extra strength
   —capsules and tablets
   —in combination with other products, both RX and OTC.

PART 2. COUGH AND COLD PREPARATIONS

I. Making a diagnosis—the common cold
—caused by a virus (no cure)
—runny nose or stuffiness
—sore throat
—cough (dry or productive)



Frozen Assets

Of the 17 years of patent life granted to new chemical entities, almost one-half of that life can be frozen in the developmental and regulatory process, leaving an average of only nine and a half years to recover development costs.

Surprising? Yes. But the real surprise is that today's drugs consume only 8 percent of all health care costs as compared with 16 percent 40 years ago.

Lilly

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—fever (slight)
—aches and pains

1. What you can do without taking medications:
   - —rest
   - —fluid (hydration important: mention chicken soup)
   - —eating well
   - —vaporizer
   - —gargle
2. If your cold is serious and requires medical attention
   - —fever over 101°F
   - —pain (moderate to severe)
   - —can't breathe or catch breath
   - —mucus which is thick, greenish or bloody
   - —rash
   - —symptoms which last more than one week
3. Choosing a product to provide relief of symptoms:
   No product provides complete relief
   Avoid combination products (more costly and may not need all ingredients for your symptoms)
4. What to take for aches and pains:
   aspirin or acetaminophen
5. What to take for sore throat:
   - —gargle
   - —hot tea
   - —hard candy
   - —lozenges (benzocaine—avoid if allergy; watch sugar content)
6. What to take for runny nose and congestion:
   - —Decongestants (topical: nasal spray; systemic: tablets or syrups)
     But avoid if:
     - —you take medication for high blood pressure (it causes heart palpitations)
     - —thyroid problems
     - —diabetes

     May cause:
     - —overstimulation
     - —paradoxical drowsiness
     - —dependence, if using nasal preparation. Follow directions.

     Do not use nasal sprays (or drops) and oral decongestants at the same time
   - —Antihistamines (tablets or liquids)
     Avoid if:
     - —prostate problems
     - —certain types of glaucoma

     May cause:
     - —drowsiness
     - —may interfere with vision
     - —interact with prescription medicine you are taking
7. What to take for cough:
   - —expectorant, brings up mucus, need to drink plenty of fluids for it to work properly
   - —dextromethorphan (''D.M.'') cough suppressant for dry, hacking cough
   - —codeine, a narcotic, may require a prescription

PART 3. LAXATIVES

I. Making the diagnosis—What is constipation?

Laxatives are one of the most abused medications.

II. Prevention is the best medicine

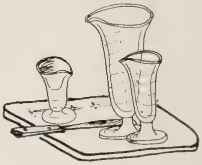
1. Diet
   - —roughage
   - —fluids
2. Activity
   - —moving about, getting out of bed or chair

3. Do not postpone or delay when urge occurs

III. **Causes of constipation**

- —many diseases
- —many medications
- —diet or lack of adequate fluid intake
- —change of environment
- —stress

1. Choosing a laxative:
    - —try the mildest first
    - —"natural" may be strong and cause cramping
    - —needs to be taken correctly to work,
      e.g. Bulk laxatives must be taken in plenty of water
      Stool softeners are mainly used to prevent constipation
      Do not crush laxative pills



2. And watch out:
    - —some laxatives are high in sugar
    - —some are high in salt
    - —some may interfere with absorption of nutrients
    - —many are habit-forming
    - —some interact with medications

PART 4. ANTACIDS

I. **Diagnosing hyper-acidity: due to**

- —ulcer
- —indigestion
- —heartburn
- —sour stomach

Diagnosing what causes the pain may save your life! The pain in your chest could be due to heart. Be sure before treating with antacid.

If you take an antacid and do not get relief, need to check with your doctor

1. Types of antacids available:
    - —liquids (best)
    - —tablets (chewable)
    - —with anti-gas ingredient simethicone
    - —low in salt and sugar
    - —high neutralizers
    - —some are constipating (may be used for diarrhea, e.g. Pepto Bismol®)
    - —some cause loose stools (may be taken for constipation, e.g. milk of magnesia)
2. Caution!
   Antacids interact with most medications, and should be taken at least one hour apart from any other medication unless suggested otherwise.

MAKING THE RIGHT CHOICE: With all the possible choices, the pharmacist is readily available to suggest a product to you. You are paying for this service, use it!

NUTRITION, VITAMINS AND MINERALS FOR THE OLDER ADULT

I. **Introduction**

1. Introduce self
   (Hint: involve audience in discussion)
2. How many people here take a vitamin every day?
3. What made you decide to take a vitamin (and/ or mineral)?
    - —doctor
    - —friend
    - —magazine article
    - —advertisement
4. Where do you purchase your vitamins?

II. Vitamins are not a substitute for good nutrition
(refer to pamphlet *Vitamins are Not Enough*)

1. Discuss components of good nutrition
   —what should be eaten daily for health maintenance
2. Vitamins cannot keep you young, and are not pep pills; if used too much they can be dangerous.

III. Vitamins: food supplements or drugs?

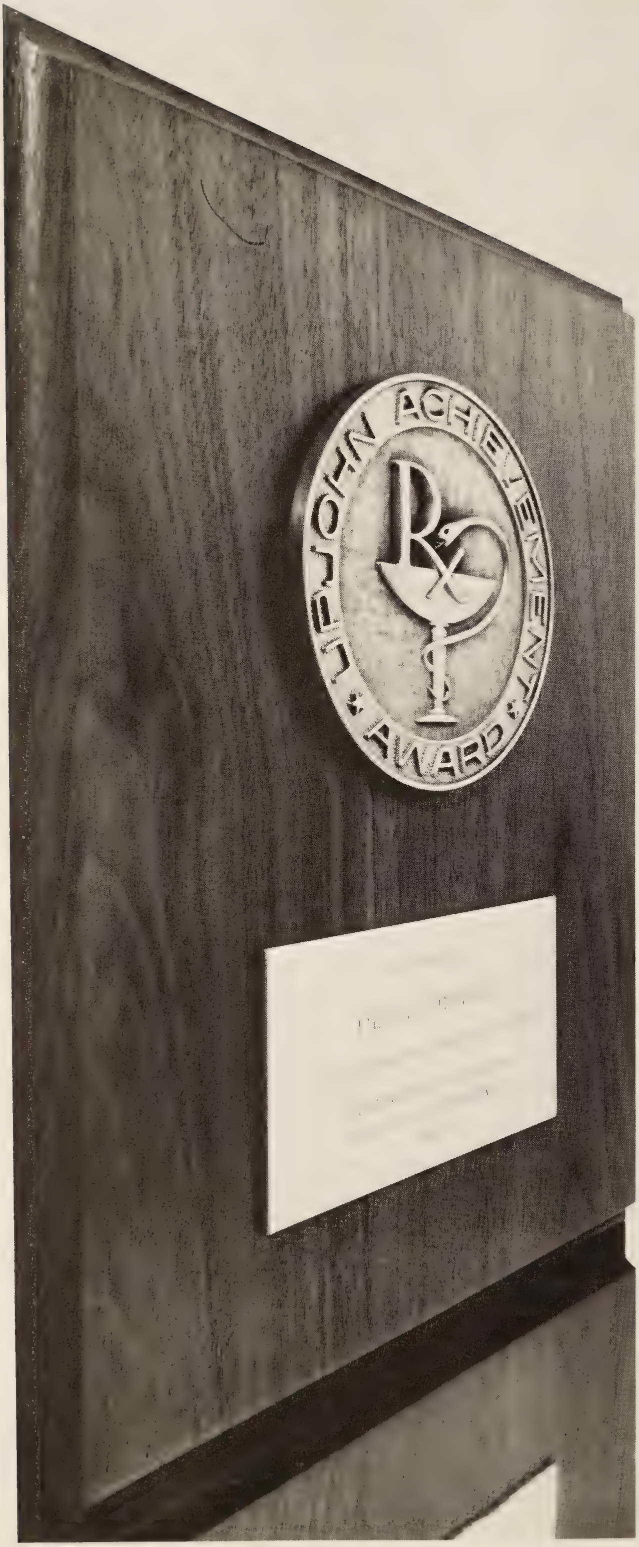
1. Two points of view:
   —vitamins are dietary supplements not subject to strict controls imposed on drugs
   —vitamins are viewed as drugs and should only be used to prevent a deficiency state or to treat a deficiency state.
2. Why the controversy:
   —our knowledge on the subject of human nutrition is still limited
   —most health-care providers do not study nutrition in school

IV. Vitamins:

1. Definition—organic chemical substances (contains carbon). Only very small amounts are required for health maintenance
2. Two major classes of vitamins:
   —water soluble: need to replace daily
   includes all B vitamins
   Vitamin C
   —fat soluble: can store in fatty tissue of body
   Vitamin A
   Vitamin D
   Vitamin E
   Vitamin K
3. Define R.D.A. (none established for seniors)
4. Megavitamins—extremely high doses, often used to prevent or cure diseases
   Do they? No! Many theories in popular literature, but no good scientific studies to prove this as yet

V. Some thoughts on popular vitamins

1. Vitamin C
   —when to avoid
   gout
   history of kidney stones
   if testing urine for sugar (if diabetic)
   —can it help the common cold? (know the latest information)
   —know difference between ascorbic acid and sodium ascorbate
   —explain how time-release Vitamin C works
   —explain difference between "natural" with bioflavanoids and rose hips versus synthetic Vitamin C
   —discuss differences in price and true value
2. Vitamin A
   —currently most popular as anti-cancer vitamin. Eating cooked yellow vegetables seems to provide some protection in smokers against lung cancer
   —but, only theories; never proven
   —different forms of Vitamin A may make a difference in response of individual
   —but watch out for toxicities in high doses:
   headache
   cracked lips
   excessive calcium deposits
   skin and cornea may turn yellow
   nausea and vomiting
3. Vitamin D
   —prescribed by physicians for certain bone diseases e.g. rheumatoid arthritis, Paget's disease, with calcium for osteoporosis
   —elderly home-bound may have true Vitamin D deficiency
   —too much Vitamin D may cause
   calcium deposits in joints, arteries and kidneys, may increase in blood pressure



Do you know a pharmacist who has won this Upjohn Achievement Award?

Each year it is awarded to the outstanding seniors in colleges of pharmacy throughout the country.

Selection of the recipients is made by the college faculties based on community service or scholastic achievement. We provide the plaques and a stipend.

In the 10 years of this program some 700 pharmacy seniors have received this award. As pharmacists, ourselves, we appreciate what these seniors have accomplished. We feel they should be honored and further motivated.

It is exciting to consider the contributions these fine young pharmacists will make to society in the years ahead.

Upjohn

© 1982, The Upjohn Company, Kalamazoo, Michigan

4. Vitamin E
    - —current fads (be prepared to discuss)
    - —avoid daily amounts in excess of 400 I.U. since large excess may cause
      flu-like symptoms
      mental confusion
      disorders of fat metabolism
5. Vitamin K
    - —elderly persons, particularly those who take anti-coagulant medications, should be aware of Vitamin K content of foods, particularly tea
6. Vitamin B_{12}
    - —usually only used on prescription for pernicious anemia and given mostly by injection
7. B Complex Vitamins
    - —consists of several vitamins
    - —lack of B vitamins is responsible for mental confusion (pseudosenility) and change in mood
    - —believed that Vitamin B complex is needed to resist stress more successfully
8. Other vitamins
    - —caution the elderly consumer, that from time to time, "new" vitamins are introduced (Vitamin B_{15}, for example). None have been shown to be effective; many are not vitamins.

VI. The minerals:

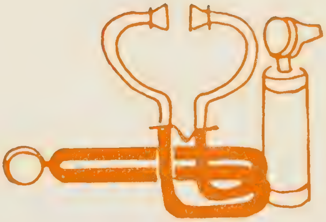
1. Definition—These are essential substances needed for health maintenance. They are inorganic substances. Some are required in comparatively large amounts (macro-elements); others in very small amounts (trace elements).

—macro-elements include	—trace elements include
calcium	chromium
chloride	copper
phosphorus	fluoride
potassium	iron
sodium	selenium
	zinc

2. A balanced diet will provide all essential minerals and trace elements in sufficient amounts.

VII. Some thoughts on minerals and trace elements

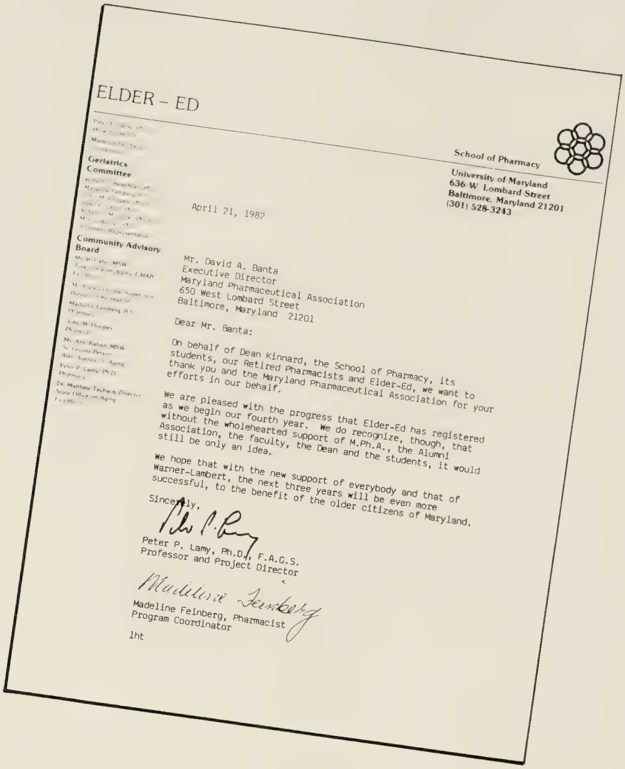
1. Iron
    - —iron is not a pep pill; it cannot "give you more energy."
    - —indications for iron therapy
      deficiency caused by loss of blood
      diagnosed iron-deficient anemia
    - —problems with taking iron
      constipating
      may cause diarrhea
      irritating to stomach and may aggrevate pre-existing ulcer
      waste of money if not needed



2. Calcium
    - —indications for supplementation
      treatment (and possible prevention) of osteoporosis
    - —is calcium alone enough? May need Vitamin D and fluoride supplementation as well
3. Potassium
    - —discuss potassium-deficiency induced by diuretic therapy
      can only be detected by blood test
      compare food sources of potassium to prescribed potassium supplementation
    - —discuss what can happen when potassium is taken without medical supervision. Before deciding that potassium supplementation is needed, talk with pharmacist.

From 11th century Chinese and Muslim sources:

> EXPERTS IN THE USE OF MEDICINES ARE
> INFERIOR TO THOSE WHO RECOMMEND A PROPER DIET.
> E.



ELDER – ED

Geriatrics Committee

[illegible]

Community Advisory Board

[illegible]

Madeline Feinberg, B.S.
Pharmacist

John M. Hooper
Pharmacist

Ms. Ann Kahan, MSW
Sr. Citizens Person
Area Agency on Aging

Peter P. Lamy, Ph.D.
Pharmacist

Dr. Matthew Tayback, Director
State Office on Aging
Ex Officio

School of Pharmacy

University of Maryland
636 W. Lombard Street
Baltimore, Maryland 21201
(301) 528-3243

April 21, 1982

Mr. David A. Banta
Executive Director
Maryland Pharmaceutical Association
650 West Lombard Street
Baltimore, Maryland 21201

Dear Mr. Banta:

On behalf of Dean Kinnard, the School of Pharmacy, its students, our Retired Pharmacists and Elder-Ed, we want to thank you and the Maryland Pharmaceutical Association for your efforts in our behalf.

We are pleased with the progress that Elder-Ed has registered as we begin our fourth year. We do recognize, though, that without the wholehearted support of M.Ph.A., the Alumni Association, the faculty, the Dean and the students, it would still be only an idea.

We hope that with the new support of everybody and that of Warner-Lambert, the next three years will be even more successful, to the benefit of the older citizens of Maryland.

Sincerely,

Peter P. Lamy

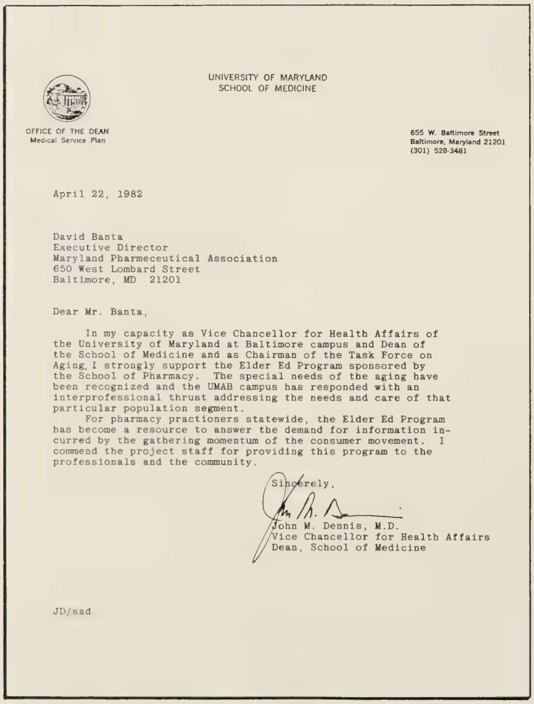
Peter P. Lamy, Ph.D., F.A.G.S.
Professor and Project Director

Madeline Feinberg

Madeline Feinberg, Pharmacist
Program Coordinator

lht

Elder Ed—Elder Healt



UNIVERSITY OF MARYLAND
SCHOOL OF MEDICINE

OFFICE OF THE DEAN
Medical Service Plan

655 W. Baltimore Street
Baltimore, Maryland 21201
(301) 528-3481

April 22, 1982

David Banta
Executive Director
Maryland Pharmeceutical Association
650 West Lombard Street
Baltimore, MD 21201

Dear Mr. Banta,

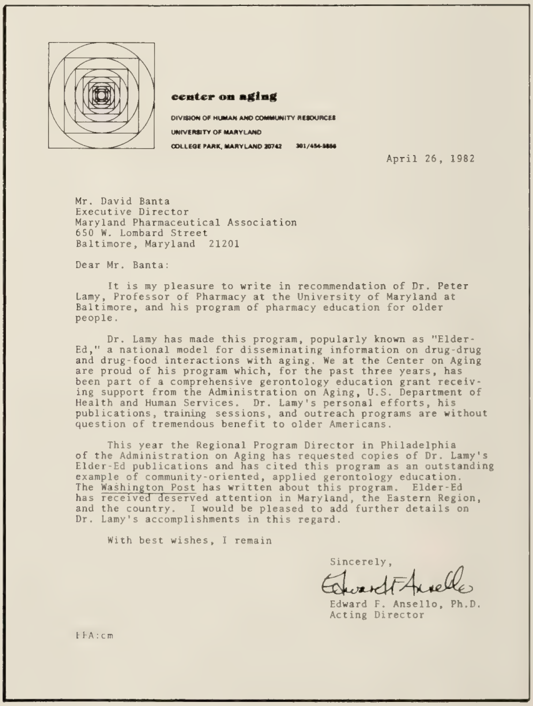
In my capacity as Vice Chancellor for Health Affairs of the University of Maryland at Baltimore campus and Dean of the School of Medicine and as Chairman of the Task Force on Aging, I strongly support the Elder Ed Program sponsored by the School of Pharmacy. The special needs of the aging have been recognized and the UMAB campus has responded with an interprofessional thrust addressing the needs and care of that particular population segment.

For pharmacy practioners statewide, the Elder Ed Program has become a resource to answer the demand for information incurred by the gathering momentum of the consumer movement. I commend the project staff for providing this program to the professionals and the community.

Sincerely,

John M. Dennis, M.D.
Vice Chancellor for Health Affairs
Dean, School of Medicine

JD/sad



center on aging

DIVISION OF HUMAN AND COMMUNITY RESOURCES
UNIVERSITY OF MARYLAND
COLLEGE PARK, MARYLAND 20742 301/454-5856

April 26, 1982

Mr. David Banta
Executive Director
Maryland Pharmaceutical Association
650 W. Lombard Street
Baltimore, Maryland 21201

Dear Mr. Banta:

It is my pleasure to write in recommendation of Dr. Peter Lamy, Professor of Pharmacy at the University of Maryland at Baltimore, and his program of pharmacy education for older people.

Dr. Lamy has made this program, popularly known as "Elder-Ed," a national model for disseminating information on drug-drug and drug-food interactions with aging. We at the Center on Aging are proud of his program which, for the past three years, has been part of a comprehensive gerontology education grant receiving support from the Administration on Aging, U.S. Department of Health and Human Services. Dr. Lamy's personal efforts, his publications, training sessions, and outreach programs are without question of tremendous benefit to older Americans.

This year the Regional Program Director in Philadelphia of the Administration on Aging has requested copies of Dr. Lamy's Elder-Ed publications and has cited this program as an outstanding example of community-oriented, applied gerontology education. The Washington Post has written about this program. Elder-Ed has received deserved attention in Maryland, the Eastern Region, and the country. I would be pleased to add further details on Dr. Lamy's accomplishments in this regard.

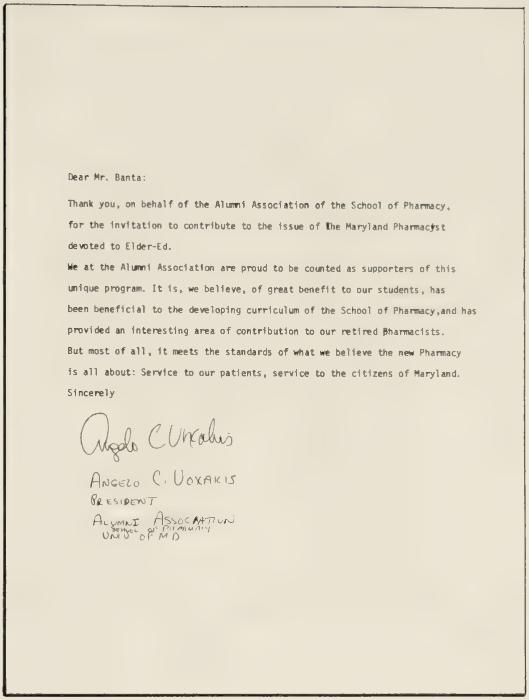
With best wishes, I remain

Sincerely,

Edward F. Ansello

Edward F. Ansello, Ph.D.
Acting Director

EFA:cm



Dear Mr. Banta:

Thank you, on behalf of the Alumni Association of the School of Pharmacy, for the invitation to contribute to the issue of The Maryland Pharmacist devoted to Elder-Ed.

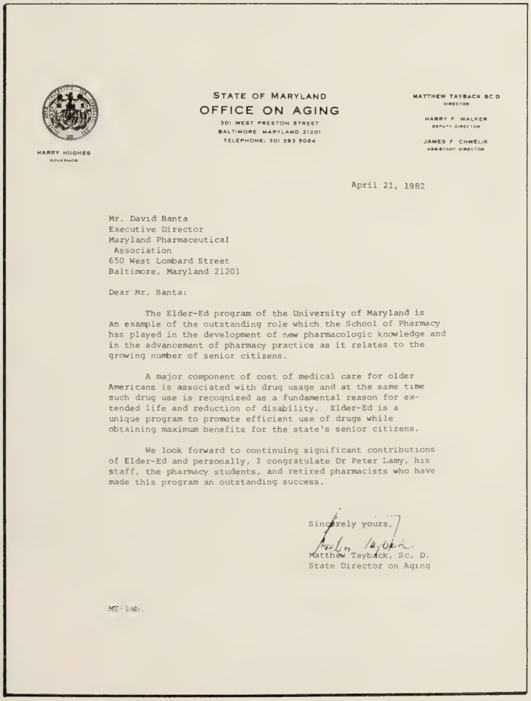
We at the Alumni Association are proud to be counted as supporters of this unique program. It is, we believe, of great benefit to our students, has been beneficial to the developing curriculum of the School of Pharmacy, and has provided an interesting area of contribution to our retired pharmacists.

But most of all, it meets the standards of what we believe the new Pharmacy is all about: Service to our patients, service to the citizens of Maryland.

Sincerely

ANGELO C. VOXAKIS
PRESIDENT
ALUMNI ASSOCIATION
SCHOOL OF PHARMACY
UNIV OF MD

Letters of Endorsement



HARRY HUGHES
GOVERNOR

STATE OF MARYLAND
OFFICE ON AGING
301 WEST PRESTON STREET
BALTIMORE MARYLAND 21201
TELEPHONE: 301 383 5064

MATTHEW TAYBACK SC D
DIRECTOR

HARRY F WALKER
DEPUTY DIRECTOR

JAMES F CHMELIK
ASSISTANT DIRECTOR

April 21, 1982

Mr. David Banta
Executive Director
Maryland Pharmaceutical
Association
650 West Lombard Street
Baltimore, Maryland 21201

Dear Mr. Banta:

The Elder-Ed program of the University of Maryland is an example of the outstanding role which the School of Pharmacy has played in the development of new pharmacologic knowledge and in the advancement of pharmacy practice as it relates to the growing number of senior citizens.

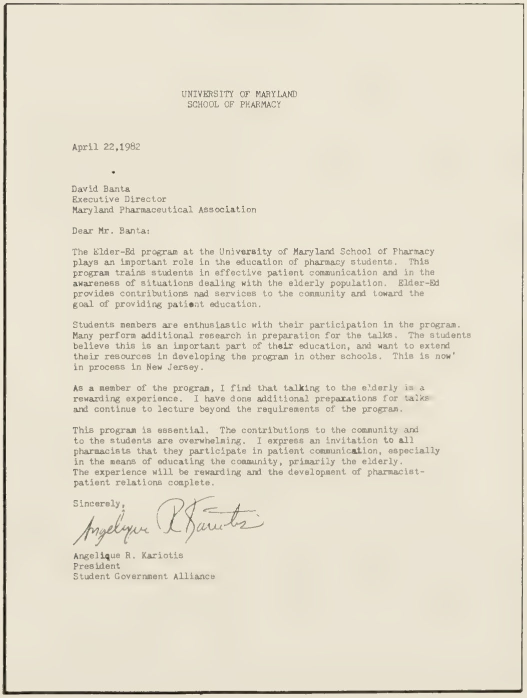
A major component of cost of medical care for older Americans is associated with drug usage and at the same time such drug use is recognized as a fundamental reason for extended life and reduction of disability. Elder-Ed is a unique program to promote efficient use of drugs while obtaining maximum benefits for the state's senior citizens.

We look forward to continuing significant contributions of Elder-Ed and personally, I congratulate Dr Peter Lamy, his staff, the pharmacy students, and retired pharmacists who have made this program an outstanding success.

Sincerely yours,

Matthew Tayback, Sc. D.
State Director on Aging

MT·lab.



UNIVERSITY OF MARYLAND
SCHOOL OF PHARMACY

April 22,1982

David Banta
Executive Director
Maryland Pharmaceutical Association

Dear Mr. Banta:

The Elder-Ed program at the University of Maryland School of Pharmacy plays an important role in the education of pharmacy students. This program trains students in effective patient communication and in the awareness of situations dealing with the elderly population. Elder-Ed provides contributions nad services to the community and toward the goal of providing patient education.

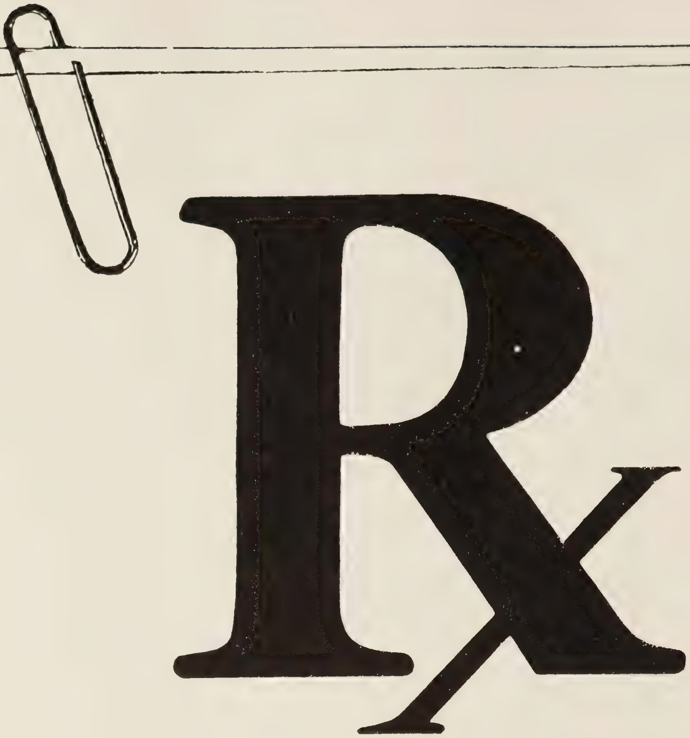
Students members are enthusiastic with their participation in the program. Many perform additional research in preparation for the talks. The students believe this is an important part of their education, and want to extend their resources in developing the program in other schools. This is now' in process in New Jersey.

As a member of the program, I find that talking to the elderly is a rewarding experience. I have done additional preparations for talks and continue to lecture beyond the requirements of the program.

This program is essential. The contributions to the community and to the students are overwhelming. I express an invitation to all pharmacists that they participate in patient communication, especially in the means of educating the community, primarily the elderly. The experience will be rewarding and the development of pharmacist-patient relations complete.

Sincerely,

Angelique R. Kariotis
President
Student Government Alliance



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President Phil Cogan (left) and President-elect Milton Sappe (right) enjoy tearing up the mandatory price posters on the steps of the Kelly Building. The passage of Association sponsored HB1170 allows Maryland Pharmacists to take down their price posters on July 1, 1982.

Dr. Peter Lamy, head of the University of Maryland School of Pharmacy's Elder Ed program discusses medications with members of a B'nai Brith Women's group in Baltimore following a presentation on proper drug use. The Elder Ed program was recently the recipient of a major grant from the Warner-Lambert Company to continue its work which is gaining national recognition. In addition, the Association has adopted the Elder-Ed program as a model for its Centennial Speaker's Bureau. (See article on page 4).

Ian Turner of the I.C. Systems has been honored by his company for ranking third nationally in collection returns for members in 1981. I.C. systems is the Association's endorsed collection agency. Turner works out of Mount Airy, Maryland. Contact the M.Ph.A. for information on their program.

Bob Green was also congratulated by I.C. systems for ten years as a District Manager. Headquartered in Joppatown, Green has added 2200 clients to the program in Maryland. I.C. system has collected $52 million last year for members of 1000 state associations nationwide.

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A Brief History of USPHS Pharmacy in Maryland

George F. Archambault

Continued from the May Issue

PART V

Commissioned Pharmacy Officers—Indian Health Service, USPHS

The first U.S.P.H.S. pharmacist officer assigned to the Indian Health Service was Allen J. Brands in 1954. Over the years, the utilization of commissioned and civil service pharmacists in the Indian Health Service has grown with the advancement of clinical and institutional pharmacy until today (1982) the compliment is 301. Currently the acting chief of this service is Mr. Charles V. Erdeljon, a former official of the PHS's Emergency Health Preparedness Division and a former VA Chief pharmacist.

Other than Mr. Erdeljon's involvement as head of this segment of pharmacy in the Public Health service with offices in Rockville, MD (PHS and Indian Health Service headquarters), this activity does not impinge on PHS pharmacy in Maryland and is mentioned here only to indicate that this service is indeed a large user of pharmacists though mainly in the Western states. These 301 pharmacists service a total of 112 Indian facilities. (Hospitals and clinics.)

Unfortunately, we do not have available to us at this time the names of the Maryland pharmacists attached to this service.

PART VI

USPHS Pharmacists in the U.S. Coast Guard

Here again because the commissioned pharmacists of the USPHS service do not serve Maryland bases, we report their presence only to indicate the PHS commissioned officer pharmacists role nationally. Currently there are six officers attached to the Coast Guard. Pharm. Dir. Samuel Ingraham of Bethesda, MD involved at Headquarters, (Wash. D.C.) in Health personnel manpower assignments. Other pharmacist officers currently on duty with the Coast Guard are pharmacist Director Vince Fierro, Chief Pharmacist, Coast Guard; Robert Branagan, Cape May, N.J., Thomas Dolan, Governor's Island, N.J., Charles Veach, Coast Guard Academy, Groton, Conn. and Phillip Lawrence at the Alameda, California Coast Guard Station.

PART VII

National Library of Medicine—Bethesda, MD

The National Library of Medicine at Bethesda, Maryland is well known to hospital, research, and academic pharmacists as well as physicians, nurses and others seeking biomedical information. Its *Medline* world-famous information service operates on NLM's Computer system. A commissioned pharmacist officer, highly trained in this medical library research work has been assigned to the Library since the late sixties—William H. Caldwell. NLM's most important publication is its Index Medicus, published since 1879. Some 20,000 plus bibliography references from journal articles are added monthly. An excellent article on the N.L.M., its scope and goals written by William H. Caldwell, a graduate of the Univ. of New Mexico College of Pharmacy and Henry M. Kissman, M.D. appears in Hospital Pharmacy Management Journal Vol. 8 No. 4, April 1973.

PART VIII

PHS Commissioned Pharmacy Officers Assigned to Fort Dietrich, Maryland

The following officers were assigned to this base during the years indicated. They served at this duty station as the Liaison officer to the Office of the Surgeon General, U.S.P.H.S.:

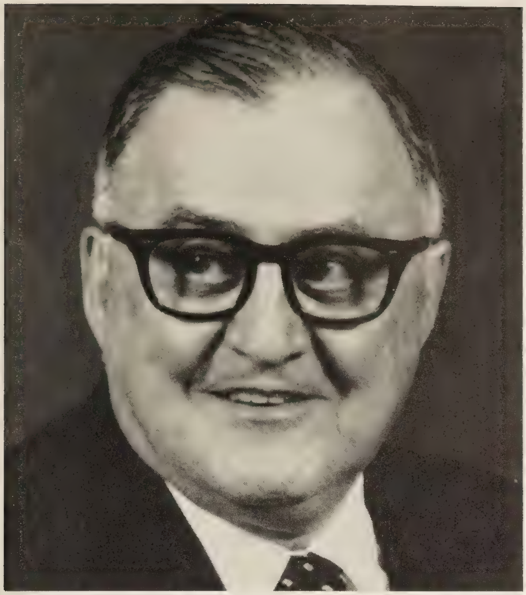
1. Pharm. Dir. (equivalent to Navy Capt.) Boris Oshenoff. 1960 – 1963
2. Pharm. Dir. (equivalent to Navy Capt.) Kenneth Hanson. 1963 – 1966

PART IX

Bureau of Prisons—Public Health Service—Commissioned Pharmacist Officers

Pharm. Director Richard Bertin of the Office of the Ass't. Sec. for Health of HHS informs us that currently there are *8* commissioned pharmacy officers serving in the Bureau of Prisons. They are stationed at Terminal Is. Cal., Lompoc, Ca., Lexington, Ky., Fort Worth, Texas, La Tuna, Texas, Atlanta, Ga. and Lewisburg, Pa.

Of the eight, none are graduates of the Univ. of Maryland College of Pharmacy or are residents of Maryland.



GEORGE F. ARCHAMBAULT, J. D., Sc.D., received the first annual President's Award of the American Society for Pharmacy Law. The award, sponsored by Merrell Dow Pharmaceuticals Inc., is presented to an individual who has made a significant contribution to the legal system in relation to the practice of pharmacy.

PART X

P.H.S. Headquarters

The headquarters of HHS-PHS is located in Rockville, MD on Fishers Lane. Over the years, the headquarters office has utilized the services of the Pharmacy Category of Commissioned Officers along with the other health disciplines, medicine, nursing, vet. med., sanitation officer, engineers, and others.

The pharmacists currently on duty at this station and who reside in Maryland are Pharm. Dir. Richard Bertin, Senior Pharm. William M. Peterson, Jr. and Senior Pharm. Richard Taffet, all assigned to the Office of the Ass't. Sec. for Health.

PART XI

Chief Ranking Pharmacist Officers—USPHSC

The three chief ranking pharmacist officers of the Commissioned Corps, each with responsibility for over all pharmacy activities in the service and reporting directly to the Surgeon General are or were Maryland residents.

George F. Archambault, Bethesda, MD	1950–1967
Allen J. Brands, Bethesda, MD	1967–1981
Richard Ashbaugh, Rockville, MD	1981–

Ass't. Surgeon General Rank for Pharmacist Officers

To date four pharmacists have attained the rank of Ass't. Surgeon General. In order of appointment these are:

Edward Duncan—Duquesne University
Allen Brands—University of Southern California *(Chief, Pharmacist Officer—Retired)
Jerome Halperin—Rutger's University
Richard Ashbaugh—Temple University (Chief, Pharmacist Officer)

All are or were *Maryland based* at the time of their assignments.

PART XII

The Inactive Reserve

Over a hundred pharmacists were commissioned in the Reserve Corps in the war years. Well known names that come readily to mind are:

R. W. St. Clair—Massachusetts College of Pharmacy (Faculty)
Donald Francke (deceased)—University of Michigan
Wm. M. Heller—U.S.P. Official
Joseph Valentino—U.S.P. Official
George P. Hager—Retired Dean, School of Pharmacy, University of North Carolina
Robert P. Fischalis (deceased)—Executive Director (Retired), American Pharmaceutical Association

PART XIII

Conclusion

A reading of this short history of PHS pharmacy and pharmacists in and of Maryland is by its very nature an incomplete one. Apologies are made for names inadvertently ommitted and duty stations not remembered. Readers are invited to add to this report by letters to the editor of this Journal for publication in later issues to help complete "the record."

calendar

June 6–10—ASHP Annual Meeting, Baltimore
June 18–20—MSHP Annual Seminar, Williamburg
June 20–24—*MPhA CENTENNIAL CELEBRATION CONVENTION-OCEAN CITY*
Nov 4–7—SAPhA Regional Convention, Baltimore
Oct 10–14—NARD Convention, Boston

Every Sunday Morning at 6:30 a.m. on WCAO-AM and 8:00 a.m. on WXYZ-FM, listen to Phil Weiner broadcast the Pharmacy Public Relations Program "Your Best Neighbor," the oldest continuous public service show in Baltimore.

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* Promoted to Assistant Surgeon General rank by virtue of new legislation introduced by Congressman Mickey Leland (D. Texas) establishing by law the grade of the Chief Pharmacist Officer of the service.

ABSTRACTS

Excerpted from PHARMACEUTICAL TRENDS, published by the
St. Louis College of Pharmacy; Byron A. Barnes, Ph.D., Editor
and Leonard L. Naeger, Ph.D., Associate Editor

CHILDHOOD ALLERGIES:

Certain types of allergies seem to subside as one ages and children who experienced bronchiolar asthmatic attacks may suffer less as they age. Two types of allergens, house dust and rye grass, were studied in children for a five-year period of time. These two allergens were selected for study because house dust is a perennial allergen while rye grass is classified as an intermittent seasonal allergen. Results indicate that if the child is in constant contact with the allergen, e.g., the perennial allergen such as house dust, symptoms tend to decrease with age. However, in the case of seasonal allergens, symptoms may remain into adolescence and adulthood. *Lancet,* Vol. II, #8260, p. 1359, 1981.

DIABETES MELLITUS:

Insulin-dependent diabetes mellitus is a condition thought to be due to inherited susceptibility and environmental factors. Studies indicate that the onset of beta-cell destruction even in children may preceed the development of clinical symptoms by as much as several years. Studies are being conducted to determine if it might be feasible to detect patients in their prediabetic state with the goal of searching for ways to prevent the beta-cell deterioration and/or using patient education to help minimize and control their condition. *Lancet,* Vol. II, #8260, p. 1363, 1981.

PEPTIC ULCERS:

Bleeding peptic ulcers can lead to death and rapid intervention is often necessary in order to prevent serious consequences. Ulcer patients in England were divided into two groups, and one group was subjected to photocoagulation therapy with an argon laser while the other group served as control. Results were encouraging in the laser-treated group and these authors suggest that this procedure be considered for use more frequently when serious bleeding ulcers are encountered. *Lancet,* Vol. II, #8259, p. 1313, 1981.

KETAMINE:

Ketamine is an analog of PCP which has found particular usefulness as a general anesthetic in children. In addition to its action on the central nervous system, ketamine also causes relaxation of skeletal muscles. A study of ion flow at the skeletal muscle receptor site indicates that the prolonged action potential associated with the ketamine-induced muscle relaxation is due to a blockade of sodium channel inactivation rather than to a delay in potassium conduction. Investigators have speculated that this interference with ion flow may also be responsible for some of the weak hallucinatory reactions noted in some people who receive ketamine. *J Pharmacol Exp Ther,* Vol. 219, #3, p. 638, 1981.

PARATHYROID HORMONE:

Uremic patients suffer from bleeding tendencies, but thus far no explanation has been presented to elucidate this finding. Platelet aggregation is affected by various endogenous materials. Aggregation becomes more likely in the presence of thrombin, collagen, ADP, serotonin, catecholamines and thromboxane A-2 while the opposite effect is seen when adenosine, prostaglandin D-2 and/or prostacyclin is present. Since there seemed to be no abnormalities in the concentration of any of these substances in the uremic patient, another agent must be causing the problem. Investigators now feel that parathyroid hormone is a major uremic toxin and is the agent responsible for producing bleeding tendencies in uremic patients. *Lancet,* Vol. II, #8259, p. 1321, 1981.

ALPHA ADRENERGIC AGENTS:

Several new drugs have been found to act on the alpha adrenergic receptor site. Cirazoline is a drug which acts specifically on the alpha-1 site in a manner similar to that exerted by phenylephrine (Neosynephrine). Prazocin (Minipress) blocks this site selectively. Agents which stimulate alpha-2 receptor sites include clonidine (Catapres), tramazoline and azepexole. These drugs are being used experimentally to study the location of specific subtypes of alpha receptors. *J Pharmacol Exp Ther,* Vol. 219, #3, p. 760, 1981.

TERBUTALINE:

High density lipoproteins are considered beneficial lipoproteins and elevated levels are associated with a reduction in the risk of coronary artery disease. These substances apparently remove cholesterol from the cell and take it to the liver for excretion. Patients receiving terbutaline (Brethine) were found to experience an increase in the concentration of high density lipoproteins thus suggesting that this anti-asthmatic agent may have some use in controlling cholesterol levels in the tissues. *N Engl J Med,* Vol. 305, #24, p 1455, 1981.

ESSENTIAL HYPERTENSION:

Blood pressure increases with age and in proportion to the sodium content of the plasma. In a study of 42 patients, data accumulated suggest that the elevation of sodium in the serum of hypertensive patients may be due in part to the increase in the concentration of an inhibitor of sodium transport which accumulates in patients with the condition. Efforts are being made to identify this transport inhibitor and see if it might be removed in order to help reduce blood pressure. *Br Med J,* Vol. 283, #6303, p. 1355, 1981.

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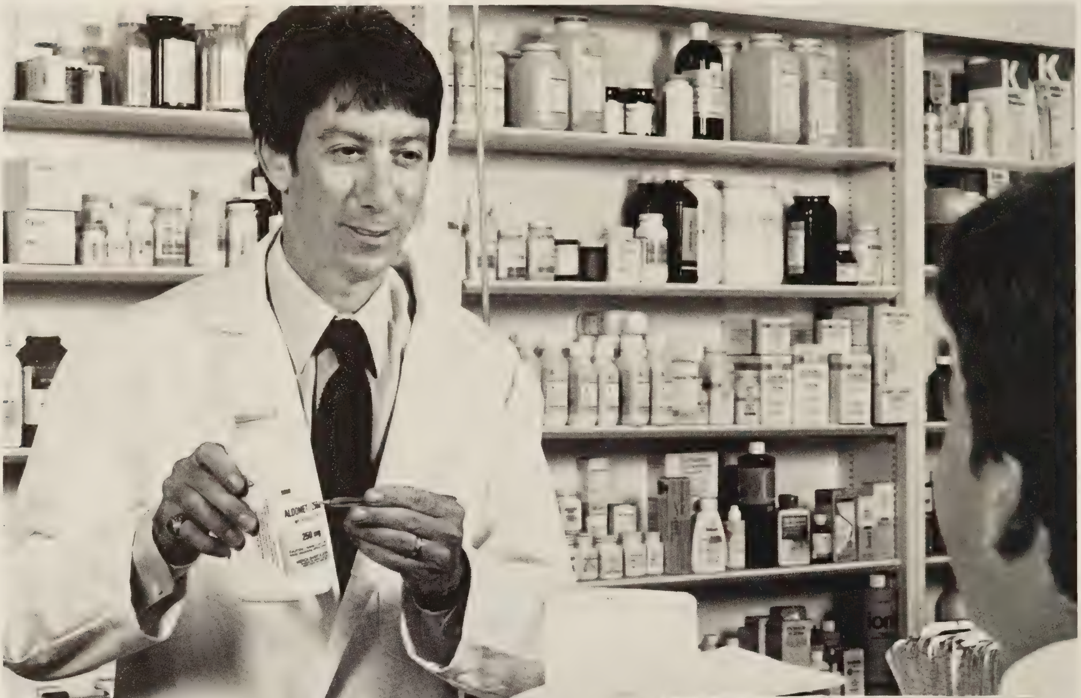

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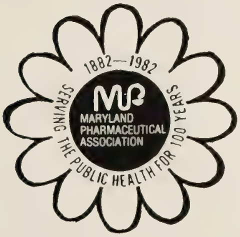
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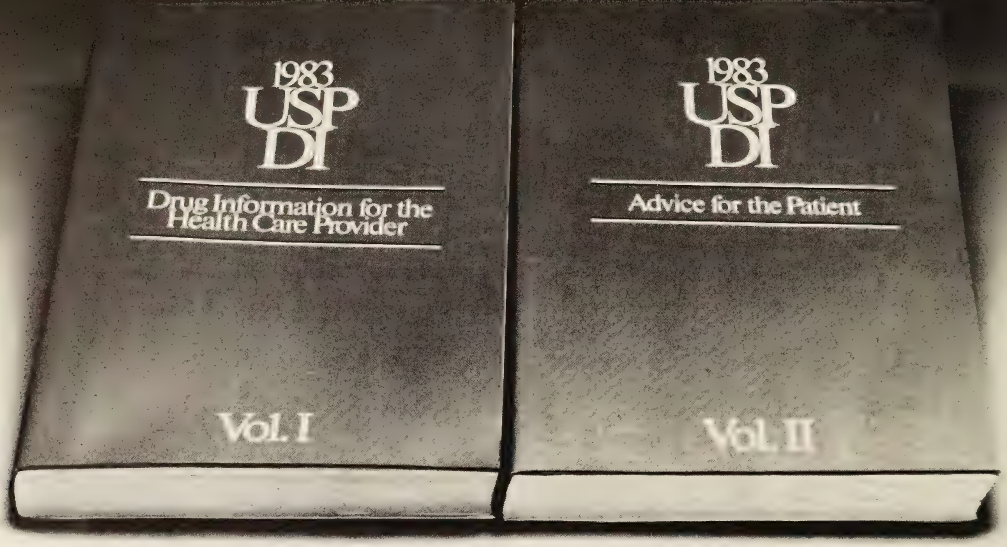

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Chemically Impaired Pharmacists —

— Intervention Programs — *Tony Tomasello*
— An Overview of the Problem — *Dudley Demarest, Jr.*

Sales Tax in Maryland

Computers in Pharmacy: The Law Changes

—Angelique Kariotis

THE MARYLAND PHARMACIST

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Guest Message

I am pleased to address Maryland Pharmaceutical Association as both a member of MPhA and President of Maryland Society of Hospital Pharmacists through this editorial.

As a new graduate I often questioned the purpose and the operation of MPhA and M.S.H.P. Frankly, it took a number of years to begin to understand the operation of these organizations. Now I find myself the President of M.S.H.P.

An obligation of these societies should be to make it easy for the new pharmacist to contribute to his/her profession through society activity. There is no doubt that there are many young practitioners who would serve if asked. I am not talking about recruitment to fill the roster. I am talking about encouraging these people to actively display their interest and talent to mold the future of the profession. Therefore one of my goals for the coming year is to attract and welcome the new pharmacist and the inactive pharmacist into society life now. Hopefully I will be able to help develop a process through these organizations that will make it easier for the talented young people in our profession to contribute early in their careers.

One of the obligations of the profession through the society structure is to develop the future leaders. With some effort on our part to attract and develop these practitioners and efforts on the part of the new or inactive professional to contribute, the coming year should be more rewarding for all of us.

Thank you for allowing me to share these thoughts with you.

Steven S. Cohen, President

MARYLAND SOCIETY
OF HOSPITAL PHARMACISTS

Intervention Programs for Impaired Professionals: Where Are the Pharmacists?

by Tony Tommasello, Pharm.B.S., M.S.

About 70 percent of adult Americans drink alcohol and of these about 6 to 10 percent develop alcoholism (1). Taking this estimate at face value it can be suggested that 180 to 280 of the 2,800 pharmacists in Maryland are or will become alcoholic (2). Others will become dependent on other drugs. However other research indicates the presence of an apparent positive relationship between alcoholism and higher educational attainment (3) implying that the number may be at the upper end of this range.

Other helping professions have taken a hard look at these figures in their respective fields and have come up with estimates of alcoholism in their colleagues. For instance, it has been estimated that 13,600 to 22,600 physicans nationwide are or will become alcoholics, or otherwise chemically dependent (4), and 40,000 to 45,000 are or will become impaired according to other estimates (5). Physicians have led the professions in developing programs to aid a colleague who is suffering from alcoholism or chemical dependence.

Concern for one's colleague, assessment of need, and expertise within the profession led to the development of specific programs which reach out to impaired physicians and offer help. While programs differ somewhat from state to state a basic tenent is that all guarantee that intervention will not harm the physician (6). The program is basically a networking system which allows an individual to express concern about a physician whom they suspect may be impaired or have a chemical dependency problem. The individual contacts a special committee of physicians by telephone, his name and phone number are taken and the committee chairman calls him back. It is the chairman's responsibility to get pertinent clinical data to insure that intervention is justified. The chairman may request that a second caller contact him in order to verify the information. Once a decision has been made to approach the impaired physician, the chairman selects, from a body of volunteers, two physicians who will visit the troubled doctor. Their job is to talk with him, help him recognize his problem, and recommend treatment. Many of the volunteers are recovering from chemical dependence themselves and are aware of the sensitivity surrounding this initial contact. The troubled doctor is in no way obligated to see the volunteers. No records are kept and no State boards are notified that a report has been made.

In 1977 the New York State legislature passed a law requiring that any physician who is aware of misconduct on the part of another physician must report this to the board of professional conduct. However a new law, passed in April 1980, established a three year trial period during which the impaired physician's committee is exempted from reporting. After this time the program will be evaluated. The troubled doctor is well protected since the New York physician's committee will never directly report him to the board of professional conduct and the chairman is prohibited by law from giving information to the initial caller or anyone else not directly connected with the case.

In Georgia the State Medical Association implemented the Disabled Doctors Program in 1975. In a five year period 297 physicians were contacted through the program. 240 entered treatment and 57 were judged to be inappropriate or rejected. A report of the program indicates that 156 physicians have been successfully rehabilitated and returned to practice (7). In Maryland there are about 50 referrals per year from a base of about 7,000 physicians. It is reported from the Hazelden alcoholism treatment unit that the physicians' response to treatment is more favorable than for other patients in the same unit (8).

Other health professions in the State of Maryland, including nursing, dentistry and law, have instituted programs modeled after the physicians' program. It is worthwhile to note that Maryland is considered a leader in this field (6).

Research and experience have indicated that there are several risk factors that are associated with alcohol and drug abuse amongst health professionals. A long standing hypothesis for high rates of physician drug use is the legal accessibility of drugs (9). However recent research findings implicate job stress as an equally if not more important factor (9). Other common explanations are overwork (10), physical ailment, poor self-concept, high level of aspirations (11) and fatigue reduction (12).

Whatever factors predate drug use, the effects of alcoholism and other chemical dependency are devastating not only to the individual but also to his family. A survey of alcoholic physicians found that they suffer the same medical consequences evident in the general population of alcoholics (4). The Georgia program identifies six areas in the life of the alcoholic physician that deteriorate as the disease progresses. Listed in order they are: Community involvement, Family life, Employment patterns, Physical status, Office conduct, and Hospital duties (7).

There is so little research in this area with regards to pharmacy that one can only make assumptions based on the experience of the physicians' programs. One can only guess how pharmacists would respond to questions which access stress such as "too much responsibility for people" and "work overload" or "lack of participation in decision making" (9). In spite of the lack of specific data relating to pharmacy, the application of general population statistics regarding alcoholism mentioned in the opening of this article signal a need for action.

It is encouraging to note that within the past several months some state boards of pharmacy and the American Pharmaceutical Association as well have begun to focus on the impaired pharmacist. There is a common understanding amongst these organizations that a nonpunitive approach to our colleagues in distress is preferred (13, 14, 15).

An immediate course of action is to begin educating our colleagues about alcoholism and chemical dependency in general. Significant advances are now taking place at the University of Maryland at Baltimore in general (13), and at the Pharmacy School in particular. However an additional effort must be made to reach pharmacists in practice through continuing education programs.

Given the successful track record of professional intervention programs it is suggested that the time is right for launching a Pharmacists' Program for Impaired Professionals. The program would be designed along the lines of the physicians' program with particular emphasis on the helping aspects and a guarantee of confidentiality for the troubled pharmacist.

Finally, research is sorely needed in this area to characterize the specific needs of the Pharmacy profession in this area. Physicians have offered some guidelines regarding specific research needs and methods (14).

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An Overview of the Impaired Pharmacist—Problem and Solutions

by
Dudley Demarest, Jr.*

The need for professional association recognition of the impaired practitioner was first addressed over a year ago. Since that time, not only has the American Pharmaceutical Association pursued this issue, but many state associations are actively working on local programs. This need for recognition first came to the attention of the Student American Pharmaceutical Association in late 1980.

At that time a letter from a state board of pharmacy, stating concern for the increased incidence of pharmacists appearing before the board for drug abuse related problems was given to one of the student delegates to the SAPhA Resolutions Committee. The committee, meeting in January 1981, responded to that letter with a proposed resolution entitled; ''Assistance for Chemically Impaired Pharmacists'' which read:

> Be it resolved, that SAPhA strongly urges that a preventative and rehabilitative program be developed to assist emotionally impaired and/or chemically dependent pharmacists.
>
> Be it further resolved, that an educational program be developed to enlighten pharmacists in regard to this problem, its manifestations and solutions.

The 1981 SAPhA House of Delegates had problems with the wording of the resolution and referred it back to committee. Before the new Resolutions Committee reviewed the proposal in January 1982, the SAPhA Executive Committee, seeing the need for such a resolution, and the need for student input, placed it on the agenda of each of the eight Midyear Meeting Policy Proposal Forums, to gather individual student opinions.

At the same time various states formed task forces and developed programs, in many cases with student impetus, in most cases with student involvement. It was partly because of SAPhA's involvement and the trend in the state associations, that the APhA placed the issue on the agenda of its January Professional Affairs Policy Committee. At that time the SAPhA Resolutions Committee reported to the policy committee on SAPhA's actions.

The committee also considered the steps being taken by such states as Iowa, Minnesota, and Maryland. The following policy was adopted by the APhA House of Delegates in April 1982 and its implementation awaits the action of the Board of Trustees.

The Committee recommended the Adoption of the following policy:

> 1. APhA believes that pharmacists should not practice while subject to physical or mental impairment due to the influence of drugs—including alcohol—or other causes that might adversely affect their abilities to function properly in their profession capacities.
> 2. APhA supports establishment of detection processes as well as counseling, treatment, prevention, and rehabilitation programs for pharmacists and pharmacy students who are subject to physical or mental impairment due to the influence of drugs—including alcohol—or other causes, when such impairment has potential for adversely affecting their abilities to function properly in their professional capacities.

In the past year several states have begun intensive study into the area of pharmacist impairment. Two of the most active in the area are Minnesota and Iowa.

At their 1981 annual meeting the Iowa Pharmacists Association established a task force on Impaired Pharmacists. To date the actions of the task force have been to set goals for their association's program. The Minnesota program has been dubbed PAP'M, Pharmacists Aiding Pharmacists in Minnesota.

Overall, many states are at various stages in developing programs. Many states have medical societies with active programs. Kansas is considering joining the medical society program. States such as Texas are forming their own task forces to study the issue. North Carolina has joined a program involved with health care practitioner "well-being."

---

* Dudley is a graduating Pharmacy student who completed this article as part of his special studies externship rotation in the Association's office.

The move is on with the realization that pharmacists and their associations need to be educated on the psychological problems faced by the pharmacist as a health practitioner.

The issue of the emotionally or chemically impaired pharmacist has long gone unnoticed. It seems that the attitude that the pharmacist, as a knowledgeable drug expert, trained in the pharmacology of drugs and their abuse potential, was at less risk of becoming impaired as compared to his health care counter-parts, such as physicians and nurses. This attitude pervades the profession and has limited any study into the problem.

At the time when SAPhA was considering policy on the issue, research by SAPhA staff showed the general lack of information on the well-being of pharmacists. The information at our disposal was the undocumented increase in pharmacists appearing before state boards of pharmacy on charges of drug abuse. Overwhelming data was available from the American Medical Association on the problem and its solutions. It was also recognized that an intra-professional program was needed to provide help to pharmacists in need, rather than a licence suspension and revocation without aid.

Many state boards are seeing an increase in cases of pharmacists practicing while impaired. Many schools of pharmacy are experiencing the same problem. The reason for this increase is not documented, and speculations about the increase use and abuse of drugs are not well founded. Suffice it to say that more are being reported.

Much of the information on the susceptability of health practitioners and the solutions to the problem comes from the AMA's approach to the issue. The AMA viewed "accountability to the public through assurance of competent care" as the primary purpose of any program. At the same time one cannot deny the moral obligation the profession has to assist its members with their problems as they relate to the practice of that profession.

The AMA's Council on Mental Health provides the following guidelines (para-phrased here)

1. It is the physicians ethical responsibility to recognize and approach a colleague's inability to practice by advising the impaired practitioner or by following the sequence:

   a) Discuss with others close to the physician
   b) Refer to the staff or administration of a hospital
   c) Refer to a specific committee of the state association

   "It should be (a committee) created exclusively for (this) purpose, not an existing one, such as an ethics or a grievance committee."

   d) To the licensing board

2. Spouses are helpful, the Women's Auxiliary should take an active role.

3. A model law should be written to deal with the impaired physician.

4. Educational programs for medical students emphasizing their high vulnerability to psychiatric disorders, alcoholism, and drug dependence.

A recent study on pharmacists' well-being, conducted at the University of North Carolina, School of Pharmacy, showed that employee pharmacists and the "up and coming generations of practitioners ages 20–39" show an increase risk for "burn-out" which may lead to impairment. Another study with physicians shows that the risk of impairment correlates not only with accessibility to drugs but with the level of stress experienced by the practitioner.

Here at the University of Maryland, it has long been recognized that there is a general lack of pharmacy education in the area of drug abuse. This was one of the reasons that the Student Committee on Drug Abuse Education was formed. Educating pharmacists as well as students and spouses is paramount in any program aimed at helping the impaired pharmacist.

One of the problems encountered when discussing the impaired pharmacist issue concerns the definition of the term impaired. Many people find the word offensive and harsh, yet a more all-encompassing term is difficult to find. The AMA provides this definition:

> (The impaired practitioner is) one who is unable to practice with reasonable skill and safety to patients because of physical or mental illness, including deterioration through the aging process, or loss of motor skills, or excessive use or abuse of drugs, including alcohol.

Maryland is well on the way to becoming one of the primary states in its approach to aiding the impaired pharmacist. But there is still one problem that every state must face and that is the problem the AMA has labeled "the Conspiracy of Silence." People tend to ignore a problem, hoping it will go away. Pharmacists must recognize that the first step in aiding a fellow pharmacist is to acknowledge the problem, contact people who can help, and provide that needed step in the delivery of care.

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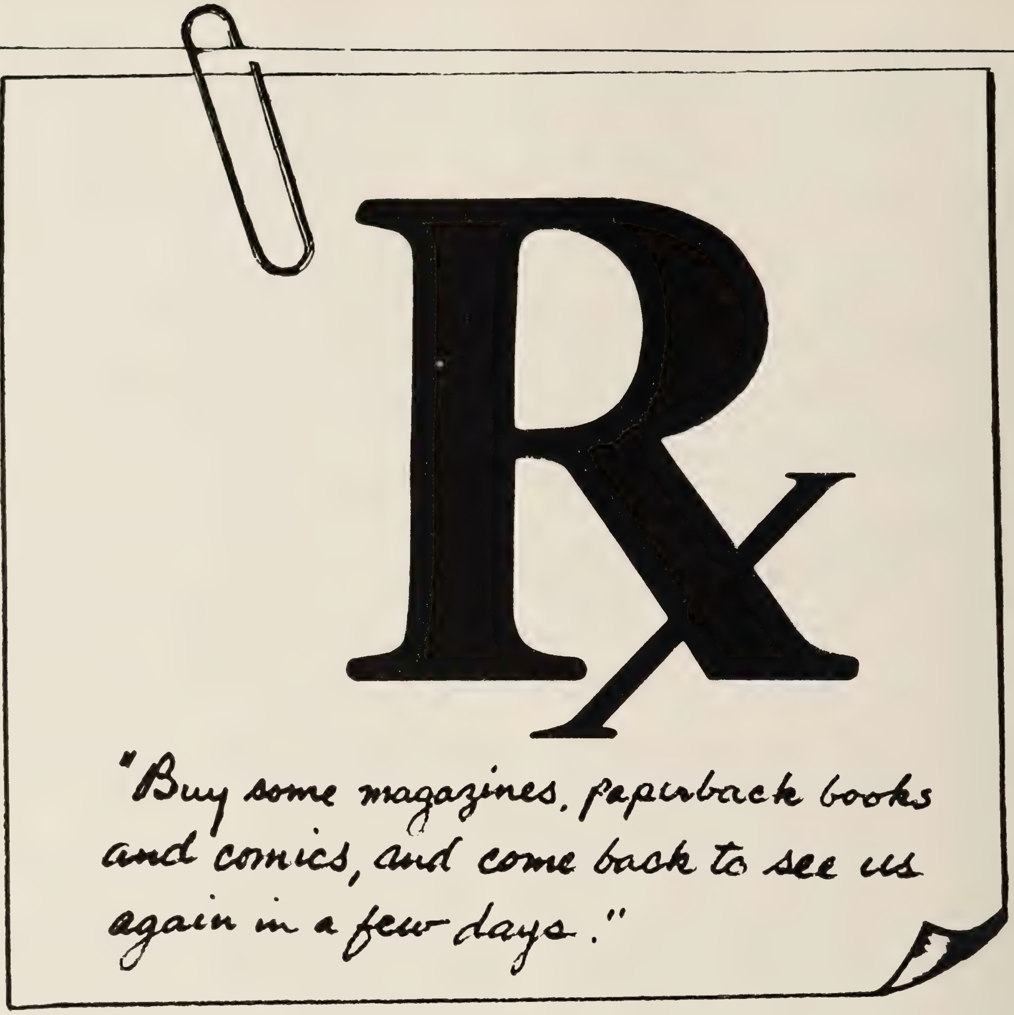
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For Your Information

Sales Tax in Maryland

Sales of tangible personal property in Maryland are presumed subject to sales tax unless specifically exempted or excluded from the tax by statute. The following paragraphs describe several exemptions in the statute, accompanied by lists of items which do *not* fall within the requirements for claiming the exemption. Sales of these items are, thus, subject to sales tax unless exempt or excluded under another provision of the statute, for example, as a sale for resale or a sale made to an organization exhibiting a sales tax exemption certificate.

Food

The Retail Sales Tax Act provides several exemptions for sales of food for human consumption, including sales of food for less than $1.00. The Act also provides a specific definition of "food". The following list contains illustrative examples of items which are not "food" under this definition, the sales of which, therefore, do not qualify for any of the exemptions for sales of food.

Alcoholic Beverages
Bottled Water
Candy
Candy-Coated Peanuts
Caramel Popcorn
Chewing Gum
Confections
Dietetic Candy
Fudge Mix
Ice
Marshmallows
Peanut Brittle
Pet Food
Roll Candy
Soft Drinks in Unopened Containers

Agricultural Supplies

The Retail Sales Tax Act provides an exemption for the sales of certain enumerated items for agricultural purposes. The following list contains illustrative examples of items which are not included in this exemption, the sales of which are, therefore, subject to tax.

Bird Seed
Christmas Trees
Fertilizer for Lawns
Flowers
Garden Tools and Equipment
Grass Seed
House Plants
Shrubbery
Wreathes

A vendor may not charge sales tax on any sale of trees, shrubbery or sod where he is obligated to plant or install these items. A vendor purchasing trees, shrubbery or sod for the purpose of resale on an installed basis shall pay the tax based on the purchase price of the item.

Medicine and Medical Supplies

The Retail Sales Tax Act provides an exemption from the tax for sales of medicines, medical supplies and sickroom equipment. The following list contains illustrative examples of items which are not medicine, medical supplies or sickroom equipment, as those terms are defined by regulation, the sales of which are, therefore, subject to tax.

Athletic Supports
Breath Fresheners
Contact Lens Cleaning Solutions
Cosmetics
Denture Adhesives
Deodorants
Disinfectants
Hair Care Products
Heating Pads
Hot Water Bottles
Pregnancy Detection Kits
Prophylactics
Sanitary Napkin Belts
Skin Creams and Lotions
Sleep Suppressants
Sunglasses (non-prescription)
Suntan Lotions
Talcum Powder
Toothbrushes
Toothpastes
Vaseline (plain)

Miscellaneous Items

Sales of the following items are also taxable unless purchased for resale or otherwise exempt by statute, for example, as a sale to an exempt entity.

Air Fresheners
Anti-Freeze
Appliance Rentals
Baby Bottles
Brooms
Brushes
Bug Sprays
Cameras
Candles
Charcoal Briquettes
Cleaning Products
Clothing
Dishes
Disposable Diapers
Dyes
Eating Utensils
Film
Film Developing
Furniture
Glassware
Glue
Greeting Cards
Hardware
Jewelry
Kitchen Utensils
Lighter Fluid
Linens
Lubricating Oils
Luggage
Magazines
Mops
Motor Oil
Musical Instruments
Paper Products
Photographic Supplies
Polishes
Pots and Pans
School Supplies
Shaving Products
Smoking Deterrents
Sponges
Sporting Goods
Stationery
Tobacco, except cigarettes
Toys
Water Softeners
Waxes

Additional information concerning this Bulletin or the taxability of items not contained in these lists may be obtained from Taxpayer Service Section by telephone at (301) 383-3800 or by letter to the above address.

A—Exempt
B—Taxable
C—Exempt to doctors only when used as medical supplies for treating patients

A	19	Abdominal Supporters
A	19	Absorbent Cotton
A	19	Adhesive Tape
A	19	Airways (Disposable)
A	19	Antiseptics
B	19	Alconox
C	19	Applicators (Wood)
A	20	Arm Pads
A	20	Arm Slings
A	20	Artificial Limbs
A	19	Axis Traction
B	19	B. P. Blades
B	19	Baby Scales
A	19	Bandages, Gauze and Plaster
A	20	Bath Bench (Medical)
A	20	Bath Lift (Medical)
B	19	Batteries, other than hearing aid
A	20	Bed Cabinets
A	19	Bed Canopies, mattress, rail
A	20	Bed Pans
A	19	Bed Wetting Alarms
A	20	Bedside Rails
C	19	Berman Tubes
C	19	Blood Bottles (one time use)
B	19	Bottles, medicine given to patient by doctor
B	19	Boxes, pill, given to patient by doctor
A	20	Braces, Arm, Leg, Spinal
B	19	Breast Pumps
A	20	Canes for Blind
C	19	Catheters (Disposable)
A	19	Cervical Collars
A	19	Cervical Scrapers
A	19	Cevitamic Acid
A	20	Chair—Table (Medical)
A	19	Chloroform
B	19	Chlorophenyl
A	19	Chux
B	19	Circumcision Shield
B	19	Clothing, Medical
A	20	Colostomy—Equipment
A	20	Colostomy—Supplies
A	19	Combine Pads
A	20	Commode Chairs
A	20	Commodes, Bedside (Medical)
A	20	Corsets, on doctors prescription
A	19	Cotton Balls
A	19	Cotton (Surgical)
C	19	Cover Glasses
A	20	Crutches
B	19	Cystoscopes
B	19	Deodorant used on patient
B	19	Diagnostic Equipment
A	19	Diagnostic Testing Material
B	19	Dialators
C	19	Diapers (Disposable)
B	19	Doctors Bags
A	19	Drainage Pads
A	19	Drainage Tubes (Disposable)
A	19	Drugs and Medicine
B	19	Dusting Powder (Surgical)
C	19	E.K.G. Paper and Jelly
A	19	Ear Basins
C	19	Electrode Jelly
A	19	Emesis Basins
B	19	Envelopes, Pill—Given to patient by doctor
A	19	Ethyl Chloride
B	19	Evacuating Syringe
A	20	Exercise Bar (Medical)
B	19	Eye Wash Cups
B	19	First Aid Kits
B	19	First Aid Station at Plants and offices, sales to
A	20	Flotation Pad (Medical)
B	19	Forceps (All types)
A	19	Gamophen Soap
B	19	Gastric Tubes
A	19	Gauze
C	19	Gloves, Plastic (Disposable)
B	19	Gloves, Rubber
A	20	Grab Bar—Bathtub (Medical)
B	19	Gravity Tubes
B	19	Gynecological Instruments
B	19	Health Garments
B	19	Heating Neck Collars
B	19	Heating Pads
B	19	Holmspray Insufflator
A	20	Hospital Beds
A	20	Humidifier (Medical) only
A	20	Hydro-Hot-Pack (Medical)
B	19	Hydrocolation Steam Pack
A	19	Ileostomies
B	19	Incontinent Pants (Baby)
B	19	Instruments
C	19	Kerlix Rolls
C	19	Kleenex
A	20	Knee Braces
B	19	Lamps, Treatment
A	19	Lubricating Jelly for Glass Eye
A	20	Mattresses (Medical only)
C	19	Medicine Tubes (Disposable)
B	19	Medicine Tubes (glass)
C	19	Modess
A	19	Mucus Trap
B	19	Murphy Saline Tubes
A	19	Nasal Tips
C	19	Needle and Suture (Disposable)
B	19	Needles
B	19	Nursing Bottles
B	19	Obstetrical Instruments
A	19	Orthopedic Appliances
B	19	Oxygen (Non-Medical)
A	20	Oxygen Inhalers
A	20	Oxygen Kits
A	20	Oxygen Tents
A	20	Oxygen—Therapy Equipment
B	19	Ozium Spray
A	19	Pads—Absorbent
A	20	Pads, Alternating Pressure (Medical)
A	20	Pads, Crutch (Medical)
A	20	Pads, Flotation (Medical)
B	19	Pads, Heating
A	20	Pants, Incontinent (Medical)
B	19	Paper Slippers
B	19	Patient Helper
B	19	Pel-Toner
B	19	Pelvimeter
A	20	Pessaries
B	19	Pharmaceutical Equipment
C	19	Plastic Disposable Gloves
B	19	Prostatectomy Instruments
B	19	Rectal Sets

'Tween Scripts

By Jake Miller, Pharmacist
Manager, Professional Relations
A. H. Robins Company, Inc.

Changing with the times. . .

Minor labeling changes will be showing up soon on many familiar "front end" products in your pharmacy as a result of the most extensive reorganization in A. H. Robins Company's history.

Our Miller-Morton subsidiary has been merged into the Company and its marketing activities for Sergeant's® pet care products, Chap Stick® lip balm and Quencher® cosmetics are now included in a new Consumer Products Division. In addition, the Robitussin® family of cough preparations, the Allbee® with C family of vitamins (including Z-BEC® Tablets), Dimetane® and Dimetane® Decongestant Tablets and Dimacol® Capsules have been shifted from the Pharmaceutical Divison to this new unit.

Quencher
DM
Sergeant's
SENTRY II
Flea & Tick Collar
Z-BEC

A. H. Robins Consumer brands . . . together after a major reorganization.

Creation of the new Consumer Products Division reflects to a large degree our Company's success in promoting sales of consumer health care products during the last several years and represents an effort by A. H. Robins to better position itself to respond to changes in the purchasing habits of its various classes of customers. The division will have its own sales force, divided between a health care/cosmetics department and a pet care department.

The shift of consumer health care products will permit our Pharmaceutical Division to concentrate on its traditional mission of marketing ethical pharmaceuticals. With new products flowing from our Research and Development Division and augmented by the injectable products produced by our Elkins-Sinn subsidiary, the Pharmaceutical Division's sales force can spend more time visiting doctors offices, pharmacies and hospitals, working to accomplish the basic goal of stimulating prescriptions for the products in our line.

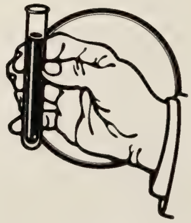
A. H. Robins has long been recognized as having one of the best sales forces in the pharmaceutical industry. From the Company's new position of effectiveness, this group of more than 500 men and women, many of whom are Certified Medical Representatives, will be able to provide even better service for you and your patient.

Jake Miller

A·H·ROBINS

A. H. Robins Company
Richmond, Virginia 23220

B	19	Restraints
A	20	Rubber Stockings
B	19	Rubber Tubing
A	20	Sacro Lumbo Supports
A	20	Safety Toilet Frame (Medical)
B	19	Sanette Bags
B	19	Scissors (all types)
C	19	Scrapers (Wood)
A	19	Septisol—Liquid Soap
C	19	Sera Sharp
A	19	Sheet Holders
A	19	Sheet Wadding
A	20	Sick Room Equipment
A	19	Silver Nitrate Solution
A	19	Soap (Surgical)
A	20	Splints
A	19	Sponges (Disposable)
A	19	Spray Bandages
C	19	Steel Gauze (Disposable)
C	19	Steel Wire (Surgical)
A	19	Steri Pads
B	19	Sterilizing Aids
B	19	Sterilizing Equipment
B	19	Sterilizing Solutions and tablets
B	19	Stethoscope Tubing
A	19	Surgi Lubes
C	19	Sutures
B	19	Syringe Bags
B	19	Syringes
A	19	Syringes (Disposable)
A	20	Table, Over bed (Medical)
C	19	Table Paper
A	20	Toilet Seats, Raised (Medical)
B	19	Tourniquets
C	19	Towels (Paper) used on patient
C	19	Trachea Tubes (Disposable)
A	20	Trapeze Bar (Medical)
B	19	Trephine Set
C	20	Truss
B	19	Tubes, Gastric
B	19	Tumor Screw
B	19	Umbilical Buttons
B	19	Umbilical Cord Clamps
A	19	Urinal Bags
A	19	Urinals
A	19	Urinary Appliances
B	19	Urine Specimen Bottle
B	19	Urolicide
B	19	Utility Sheets (Cloth)
C	19	Utility Sheets (Paper)
A	20	Walkers
A	20	Walking Heels
B	19	Waxed Bags
A	20	Wheel Chair Accessories (Invalids)
A	20	Wheel Chairs for Sick
C	19	Wood Applicators
C	19	X-Ray Developing Chemicals
C	19	X-Ray Film
B	19	Zephiran Chloride



EMPLOYEE—EMPLOYER RELATIONS FORUM

The purpose of the Forum is to deal creatively with the issues in Maryland Pharmacy employer and employee relations. This Committee of the Association is made up of individuals from a wide variety of practice settings. We are asking for input on current employment issues from all segments of the profession. The Forum will act as a "sounding board" on these issues and will provide some ombudsman activity.

Model Employment Agreement

The Employer-Employee Relations Forum feels that a clear understanding of the Employment Relationship is necessary to prevent misunderstanding by either the Employer or Employee Pharmacist. The Forum feels an agreement between the Employer and Employee Pharmacist, whether it be an informal verbal agreement or highly structured formal contract, is necessary for a mutually satisfying relationship.

The Forum therefore presents, as a service to the members of the Maryland Pharmaceutical Association, a list of job-related items which should be considered and discussed at the time of employment by the employer and employee pharmacist.

1. *Job Description.* The Pharmacist should have a clear understanding of the duties, responsibilities, and authorities that will be expected as part of the employment. In some cases employer may wish to provide a "Policy Manual" that will outline operating procedures for the employee pharmacist. This will allow both employer and employee to measure performance against an established criteria.

2. *Length of Employment.* In most instances the length of employment will be indefinite. However, the following should be discussed:

   a. Length of the "Probationary Period" if any.
   b. The duration of the agreement, if any.
   c. The conditions under which the agreement may be re-negotiated.

3. *Compensation.* As part of the compensation package, some of the following may be considered:

   a. salary (hourly or weekly)
   b. overtime
   c. Bonus and/or profit sharing. The method of arriving at such a figure should be pre-determined and agreed upon.

4. Benefits. Without intending to be all inclusive the following list of possible employment benefits is provided and if available should be clearly understood:

   a. vacation
   b. sick leave
   c. professional society membership
   d. continuing education
   e. health insurance
   f. Life insurance
   g. professional liability insurance
   h. income protection insurance
   i. retirement plan
   j. stock purchase options
   k. personal purchases-employee discounts
   l. professional attire
   m. court time (jury duty, witness)
   n. funeral leave

5. *Schedule.* While allowing for flexibility, an understanding should be reached regarding the general hours to be worked, shifts, and procedure for requesting alterations of the standing schedules. In addition, it is helpful to know specifically which days will be considered holidays.

6. *Practice Limitation.* In some practices an employee may wish to stipulate that the employee pharmacist may not work for another employer in a relief or part-time position.

7. *Arbitration of Disagreements.* It may be helpful to provide a description of the manner in which disagreements can be resolved. The employer-employee relations forum will not serve as a formal arbiter, but is available to make recommendations for arbitration.

8. *Termination.* The agreement may be formal or informal, but the amount of notice (and/or severance pay) should be specified.

In conclusion, we cannot emphasize enough the importance of regular, open communication between the employer and employee.

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Computers in Pharmacy: The Law Changes

by Angelique R. Kariotis

Angelique is a graduating Pharmacy student and researched and completed this article as part of a special studies externship rotation at the Association Office.

The Age of Computers is no longer a dream, but a part of the present time period we live in. Computers in pharmacy help expedite prescription processing, inventory control, third party billing and price updates, allowing the pharmacist "time" to manage the store, solve pharmacy problems and interact more with patients.

With the increase in the usage of computers in pharmacy, it became necessary to alter various policies and procedures within the law, within billing and within patient confidentiality. These changes are available for reference, but are in scattered form, therefore, a small attempt was made to compile as much information as was obtainable.

Changes in the Maryland Pharmacy Law are regarding the transfer of prescription records. They are as follows:

.04 Computer Transfer of Prescription Records between Pharmacies

A. A computerized transfer system shall satisfy the requirements of these regulations for prescription transferral.*

B. Stores which access the same prescription records electronically, such as independent pharmacies using a jobber data bank, are not required to cancel the original prescription.

C. Pharmacies under a single ownership which electronically access the same prescription records are not required to cancel the original prescription.

(Reproduced from the Maryland Pharmacy Law book, 1981: pages 199–200)

The Federal Drug Enforcement Agency has developed changes in their Controlled Drugs Substance refilling of prescriptions. They are as follows: (reproduced from the USP XX/NF XV Supplement 3:X pages 332–333.)

1306.22 Refilling of Prescriptions

(a) As an alternative to the procedures provided by subsection (a), an automated data processing system may be used for the storage and retrieval of refill information for prescription orders for controlled substances in Schedule III and IV, subject to the following conditions:

(1) Any such proposed computerized system must provide on-line retrieval (via CRT display or hard-copy printout) of original prescription order information for those prescription orders which are currently authorized for refilling. This shall include, but is not limited to, data such as the original prescription number, date of issuance of the original prescription order by the practitioner, full name and address of the patient, name, address, and DEA registration number of the practitioner, and the name, strength, dosage form, quantity of the controlled substance prescribed (and quantity dispensed if different from the quantity prescribed), and the total number of refills authorized by the prescribing practitioner.

(2) Any such proposed computerized system must also provide on-line retrieval (via CRT display or hard-copy printout) of the current refill history for Schedule III or IV controlled substance prescription orders (those authorized for refill during the past six months). This refill history shall include, but is not limited to, the name of the controlled substance, the date of refill, the quantity dispensed, the identification code, or name or initials of the dispensing pharmacist for each refill and the total number of refills dispensed to date for that prescription order.

(3) Documentation of the fact that the refill information entered into the computer each time a pharmacist refills an original prescription order for a Schedule III or IV controlled substance is correct must be provided by the individual pharmacist who makes use of such a system. If such a system provides a hard-

---

* These regulations include cancelling the original prescription by indicating that it was transferred, to whom it was transferred, the date of the transfer, the names of the transferring pharmacist and the pharmacist receiving the prescription.

copy printout of each day's controlled substance prescription order refill data, that printout shall be verified, dated, and signed by the individual pharmacist who refilled such a prescription order. The individual pharmacist must verify that the data indicated is correct and then sign this document in the same manner as he would sign a check or legal document (e.g., J. H. Smith, or John H. Smith). This document shall be maintained in a separate file at that pharmacy for a period of two years from the dispensing date. This printout of the day's controlled substance prescription order refill data must be provided to each pharmacy using such a computerized system within 72 hours of the date on which the refill was dispensed. It must be verified and signed by each pharmacist who is involved with such dispensing. In lieu of such a printout, the pharmacy shall maintain a bound log book, or separate file, in which each individual pharmacist involved in such dispensing shall sign a statement (in the manner previously described) each day, attesting to the fact that the refill information entered into the computer that day has been reviewed by him and is correct as shown. Such a book or file must be maintained at the pharmacy employing such a system for a period of two years after the date of dispensing the appropriately authorized refill.

(4) Any such computerized system shall have the capability of producing a printout of any refill data which the user pharmacy is responsible for maintaining under the Act and its implementing regulations. For example, this would include a refill-by-refill audit trial for any specified strength and dosage form of any controlled substance (by either brand or generic name or both). Such a printout must indicate name of the prescribing practitioner, name and address of the patient, quantity dispensed on each refill, date of dispensing for each refill, name or identification code of the dispensing pharmacist, and the number of the original prescription order. In any computerized system employed by a user pharmacy the central recordkeeping location must be capable of sending the printout to the pharmacy within 48 hours, and if a DEA Special Agent or Compliance Investigator requests a copy of such printout from the user pharmacy, it must, if requested to do so by the Agent or Investigator, verify the printout transmittal capability of its system by documentation (e.g., postmark).

(5) In the event that a pharmacy which employs such a computerized system experiences system down-time, the pharmacy must have an auxiliary procedure which will be used for documentation of refills of Schedule III and IV controlled substance prescription orders. This auxiliary procedure must insure that refills are authorized by the original prescription order, that the maximum number of refills has not been exceeded, and that all of the appropriate data is retained for on-line data entry as soon as the computer system is available for use again.

The State and Federal DEA consider the refills part of the original prescription and therefore must be accessible for inspection and are to be maintained for the life of the prescription. In the State of Maryland, prescriptions are to be kept five years after the date of dispensing the appropriately authorized refills.

Third party insurance prescription providers offer changes in the processing of third party claims generated by tape or by computer printout. Listed below is the information provided by the various companies answering our request.

	Amount of time to keep signature logs (for tape billing and computer hard copy)	**Acceptance of tape billing**	**Tape billing turnover**	**Audits**
Blue Cross	3 years	Yes	2-3 days	Verify original prescription on file and the signature.
Medical Assistance	N/A	Yes	10 days	No, unless suspect fraud.
Associated Prescription Service	2-3 years	Yes. Claim there are a great many errors with this method.	7 days	Verify the original prescription and printouts for the refills.
Prescription Drugs, Inc.	7 years	Yes	No time specified	Verify the original prescription.
Iron Workers	No time specified.	No	N/a	No audits
Group Services Corporation	No time specified	No	N/A	No audits
Pharmaceutical Card System	Life of the prescription (in Maryland 5 years)	No	N/A	Audits are done as deemed appropriate.
Metropolitan	No time specified	Yes	7 days	Audits are performed at random.

Please note: Many of these companies were reluctant to furnish information either by phone or by mail, therefore, the above information is as accurate as the person answering the questions would attest to.

One of the more controversial issues regarding computerized pharmacy is patient confidentiality. With computers, information is accessible to any person having the simplest knowledge of turning a computer on. Information can be altered or lost by someone misusing the computer. The Medical and Chirurgical Faculty of the State of Maryland recommends limited access to computerized records. They recommend some type of security or code system be built in such as alarms or passwords that only few people have access to.

Computer companies require their personnel sign a statement that as an employee of the company, they will exercise caution in handling store files, including patient and financial information, and not to discuss these files with anyone or alter these files, except to correct errors in the program. This data is private, privileged information.

Computers improve the practice of pharmacy. Now laws and procedures must be improved. As the utilization of computers increases, so will the need to make changes in policies and procedures. There will come a time when these policies and procedures will be standardized and finally written down in one place!!!

Special acknowledgments of thanks belong to the third party companies, 3 PM, Inc., Health Care Logistics, the Law School at the University of Maryland, the Maryland Board of Pharmacy and anyone else I happened to hassle in this endeavor.

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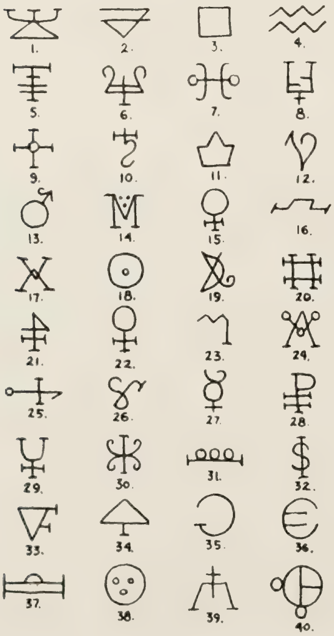
ALCHEMY SYMBOLS AND THEIR MEANINGS

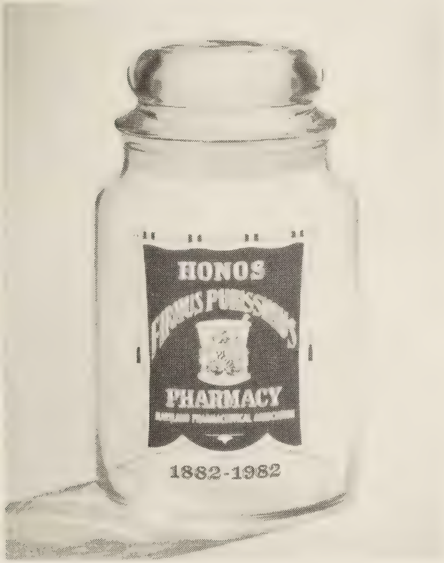


1 AIR
2 EARTH
3 FIRE
4 WATER
5 ANTIMONY
6 YELLOW SULPHURET OR ARSENIC
7 RED SULPHURET OR ARSENIC
8 POTASH
9 OIL
10 LEAD
11 BORAX
12 SPIRIT OR WINE
13 IRON
14 VINEGAR
15 CALAMINE
16 SPIRIT
17 GLASS
18 GOLD
19 VERDIGRIS
20 WINE
21 QUICKLIME
22 COPPER
23 COPPERAS
24 AQUA VITAE
25 MAGNESIA
26 MARCASITE
27 RED LEAD
28 POWDER
29 MERCURY
30 SAL AMMONIAC
31 SALTPETRE
32 COMMON SALT
33 AQUA FORTIS
34 SULPHUR
35 SILVER
36 STONES
37 TO SUBLIME
38 HUMAN SKULL
39 TUTTY
40 OIL OF VITRIOL

CELEBRATE WITH US

To commemorate its 100th anniversary celebration, the Maryland Pharmaceutical Association is issuing a special edition, custom designed apothecary jar. For a limited time only, members and friends are invited to purchase these deluxe containers in recognition of the association's first century of service.

Each glass jar is imprinted with a two-color reproduction of the Maryland Pharmacy banner and the words: "Honos, Firmus, Purissimus — Pharmacy, the Maryland Pharmaceutical Association — 1882-1982." The jars are suitable for home or office because of their wide variety of uses:



- * For countertops — to store herbs, foodstuffs
- * For desktops — to contain candy or dried fruit
- * For occasional tables — to preserve snacks or to use as a decorative accessory

No matter how you choose to use this handy apothecary jar, you will often welcome its attractive styling and utility. This jar is not available at any retail store! It has been designed especially for the association and is destined to become a collectors' item in the years ahead. Priced right for the value, you can save by ordering three or more:

$12.00 — each
$33.00 — for three — $11.00 each
$100.00 — for ten — $10.00 each

Take advantage of this offer now. Simply complete the order form below and mail it to:

MhA
650 West Lombard Street
Baltimore, MD 21201

APOTHECARY JAR ORDER FORM

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____
Telephone ______________________

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Amount Enclosed $ ______________

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Return to: MPhA, 650 West Lombard Street, Baltimore, MD 21201

LETTERS

MESSAGE FROM GOVERNOR HARRY HUGHES:

I am pleased to send greetings to all of those attending the special commemorative meeting of the Maryland Pharmaceutical Association at the Kelly Memorial Building.

Let me also take this opportunity to congratulate the association, as you celebrate the centennial anniversary of your founding.

The Maryland Pharmaceutical Association has compiled an impressive record and remarkable growth since 73 pharmacists united to serve the public interest in 1882. On behalf of our fellow citizens, I commend you.

Although I am unable to be with you, I did not want this special occasion to pass without sending my best wishes for continued success.

Sincerely,
Harry Hughes
Governor

Dear Mr. Banta,

I wanted to take a moment to thank you, Beverly, and the Employee-Employer Relations Comm. for keeping me well-informed of all the committee's activities. Regretfully, I am committed to working each Tuesday, and have been unable to resolve this time-conflict. I would like to commend the committee members on the excellent work accomplished so far. The information they have compiled will be most useful to both new pharmacists, as well as we "veterans" faced with an unfortunate amount of transience in employment. I am looking forward to further correspondence, and hope to participate more actively in the association in the future. Thanks again.

Sincerely,
Gloria Rosensweig

Dear Mr. Banta:

Through the participation of Maryland pharmacists and the support of the Maryland Pharmaceutical Association, the Drug Product Problem Reporting Program (DPPR) continues to take concerns with drug products used in pharmacy practice to the officials in government and industry who are in a position to act upon these concerns.

I would like to call your attention to a program that is similar to the DPPR. It is the Medical Device and Laboratory Product Problem Reporting Program. Medical devices, such as walkers, crutches, canes, ostomy supplies, humidifiers, various types of thermometers, contraceptive diaphragms and supplies, denture supplies, wheelchairs, hearing aids, blood pressure monitoring devices, dietary supplements and biologicals may also develop problems. Pharmacists encounter many of these products in their practice and they are in an excellent position to observe the products and any associated problems. However, the products fall under the jurisdiction of a myriad of government agencies and bureaus and it can be difficult to determine who is responsible for the various products. The USP Practitioner Reporting System can simplify the process, because USP will determine the appropriate agency and forward the report to that office.

In 1973, the Medical Device and Laboratory Product Problem Reporting Program (PRP) was initiated to provide the opportunity for health practitioners to report problems or concerns with medical devices, diagnostic equipment and/or *in-vitro* products. The PRP is a practitioner oriented system in that it communicates health hazards and product problems to appropriate government and industry officials through the United States Pharmacopeia and provides the reporter with a response.

When a pharmacist encounters a problem with any medical product, the pharmacist should state their observations on either the DPPR or PRP reporting form and return it to the USP. The problems may also be reported via the toll-free telephone line (1-800-638-6725).

If the pharmacist is not sure about the significance of a problem, he/she is asked to report it. Problems that appear insignificant at the time may be occurring with other practitioners, and a pharmacist's report could be the additional information that initiates a corrective action for a problem.

The USP Problem Reporting System is voluntary. There is no cost associated with participation in the program.

I have enclosed materials on the Medical Device and Laboratory Product Problem Reporting Program. I hope you will find it of interest and value. I would like to ask the Maryland Pharmaceutical Association to consider becoming a cosponsor of the Medical Device and Laboratory Product Problem Reporting Program.

If you have any questions, please contact me.

Thank you.

Sincerely,
Robert Moore
Project Coordinator
Practitioner Reporting System

Dear Mr. Banta:

We wish to respond to the misunderstanding which resulted from our outside counsel's oral argument before the United States Supreme Court in the *Ives* vs. *Inwood Laboratories and Darby Drugs, et al.* cases.

We want to assure you that Ives has the highest regard for the pharmacy profession and in no way intended to impugn the integrity of the nation's pharmacists who play a key role in the health care industry and are highly principled and honorable. A complete reading of the brief and the evidence before the Supreme Court reveals that our outside counsel's comment was made to, and considered by the Court *only* in the context of the evidence before it of illegal substitution by certain pharmacists, and was not intended to refer to the profession of pharmacy generally. Such evidence was important to our litigation in an effort to stop the marketing of "look-alike" pharmaceutical products.

We feel that any instance of illegal substitution and/or mislabeling is wrong, and we are sure that all pharmacists agree with us. Indeed, the profession is involved in efforts to stop this practice through the activity of their state boards of pharmacy.

Our litigation is directed against those generic manufacturers who attempt to duplicate the color, shape and size of our trademarked products.

From a realistic viewpoint, both pharmacists and Ives share a vital common goal, i.e. to provide the public with high-quality pharmaceutical products in order to optimize patient care. In line with this common goal, it is unthinkable that our company would have even considered criticizing the pharmacy profession in general.

We deeply regret any misunderstanding which may have resulted from this matter. Ives is most anxious to correct any misinformation, and to publicly proclaim our deep respect for the nation's pharmacists.

Sincerely,
Sidney Elston
Chairman, Ives

Dear Mr. Banta:

We are pleased to announce that effective June 1, 1982, Merrell Dow Pharmaceuticals Inc. will exclusively market Bricanyl® (terbutaline sulfate) tablets and ampuls, formerly supplied by Astra Pharmaceutical Products Inc.

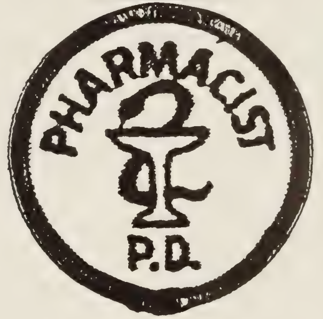
Please contact your Merrell Dow representative if you have any questions, or contact me directly.

Sincerely,
Charles D. Combs
Director Trade and Professional Relations

ANNOUNCEMENT

Two Maryland Pharmacists, both members of the Association, have announced that they will seek election to the Maryland General Assembly. They are: Don Elliott, owner of New Windsor Pharmacy who is seeking a seat in the House of Delegates, and William Skinner, Chairman of the Centennial Celebrations Committee, a Pharmacist and Attorney, seeking a seat in the Senate.

If you are interested in assisting in the campaigns of these two pharmacists, contact the Association office. There are currently no pharmacists in the Maryland General Assembly while several other health care disciplines are well represented. The Legislative Committee urges members to actively support these candidates for office who will represent the pharmacy viewpoint.



ACTUAL SIZE

Pharmacist Insignia
PATCH NOW AVAILABLE

The new emblem for pharmacists utilizing the "P.D." designation has arrived. Designed to be sewn on dispensing jackets, these new insignia are embroidered in dark blue with a white background, and cost $1.50 each.

To order, send check or money order for emblems @ $1.50 each to:

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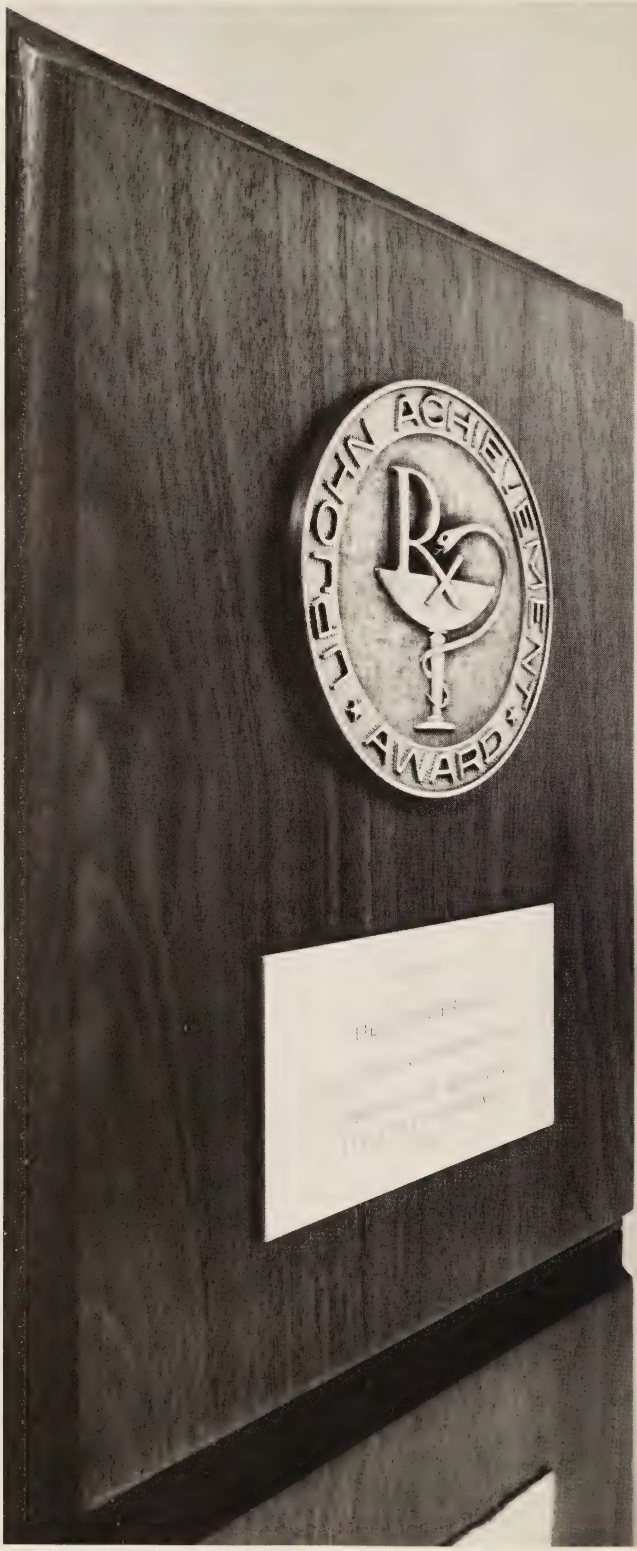

Do you know a pharmacist who has won this Upjohn Achievement Award?

Each year it is awarded to the outstanding seniors in colleges of pharmacy throughout the country.

Selection of the recipients is made by the college faculties based on community service or scholastic achievement. We provide the plaques and a stipend.

In the 10 years of this program some 700 pharmacy seniors have received this award. As pharmacists, ourselves, we appreciate what these seniors have accomplished. We feel they should be honored and further motivated.

It is exciting to consider the contributions these fine young pharmacists will make to society in the years ahead.

Upjohn

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Governor Harry Hughes (center), Jim Clark, Jr., President of the Senate (left), and Ben Cardin, Speaker of the House of Delegates (right) sign into law the Association sponsored bill which repeals the mandatory price poster effective July 1, 1982.

After the Association was informed that the Kelly Building would not be moved or destroyed to make room for the expansion of University Hospital, several delayed repairs were made, including the painting of the exterior.

Gayle Stier (left), a fourth year pharmacy student, received the M.Ph.A. Scholarship Award and Angelique Kariotis (right), a graduating pharmacy student, received the Kaufman Award from M.Ph.A. President Milton Sappe.

Brian Sanderoff (left) and Angelique Kariotis confer with Donald Fedder (right), the SAPhA Faculty adviser at the Las Vegas-A.Ph.A. convention. The M.Ph.A. provides financial assistance for the ten Maryland Pharmacy Students who attended the national convention.

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Lilly Digest

A Preview of 1981 Hospital Pharmacy Operations

This report includes selected operating data tabulated to reflect a composite profile of the "average" hospital pharmacy in the United States for 1981. Because this hypothetical pharmacy is derived mathematically from a broad range of information, the figures may be too general to use for direct comparison. However, trends can be determined by comparing the data with similar figures from the 1980 survey of operations.

The data show that the average hospital had a bed capacity of 259 in 1981—a 4.4 percent increase from the previous year and the same bed capacity as that reported in 1979. Census declined from 74 to 73 percent during 1981. Admissions increased from 8573 to 9212 (an increase of 7.5 percent), which resulted in a shorter period of patient stay—7.5 days. The largest segment of reporting hospitals continues to be private (nonprofit) general institutions.

The number of hours worked by pharmacists and technicians as well as the hours the central pharmacy was open rose during the 1981 reporting period. Overall, 2.8 hours of pharmacist time and 2.6 hours of technician time were required for each hour the central pharmacy was open during 1981. A comparison of total hours worked per week by the pharmacy staff in 1981 with similar data for 1980 reveals that total pharmacy staff requirements increased somewhat.

The dollar values reported for inventory and purchases were higher during 1981 (up 1.2 and 12.3 percent respectively). The estimated inventory turnover rate showed significant growth from 5.3 to 6.1 times. It is interesting to note that, if the inventory turnover rate had remained at 5.3 during 1981, inventory costs at $104,416 would have been over $16,000 higher and shown an increase of 16.8 percent. That hospital pharmacy managers exercised control over inventory, as demonstrated by the improved turnover rate during 1981, is particularly revealing, since last year was one of continued price increases.

Inventory and purchases on a per-bed basis were also higher than those reported in last year's *Survey*. However, because the data do not take inflation into account, it is impossible to determine the extent of its impact on inventory and purchases figures. Therefore, the amounts shown do not necessarily reflect expanded usage of drugs and related items by hospital patients.

Services offered by over 50 percent of hospital pharmacies responding to the *Survey* remained unchanged from the previous year. Monitoring of drug in-

AVERAGE HOSPITAL PHARMACY

Preliminary Report

	1981 (1694 hospitals)	1980 (2152 hospitals)	Percent of Change
Bed capacity	259	248	+ 4.4%
Class	Private (nonprofit)	Private (nonprofit)	
Profile	General	General	
Census (beds occupied)	73%	74%	
Admissions	9212	8573	+ 7.5%
Length of patient stay	7.5 days	7.8 days	
Hours central pharmacy open/week	91	90	+ 1.1%
Pharmacist hours/week	260 (6.5 F.T.E.)	243 (6.1 F.T.E.)	+ 7 %
Technician hours/week	240 (6.0 F.T.E.)	231 (5.8 F.T.E.)	+ 3.9%
Inventory	$104,416	$103,211	+ 1.2%
$ 1.51/Patient day		$ 1.54/Patient day	
$ 403/Bed		$ 416/Bed	
$ 552/Occupied bed		$ 562/Occupied bed	
$11.33/Admission		$12.04/Admission	
Purchases	$638,903	$569,045	+12.3%
$ 9.26/Patient day		$ 8.49/Patient day	
$ 2467/Bed		$ 2294/Bed	
$ 3379/Occupied bed		$ 3101/Occupied bed	
$69.35/Admission		$66.38/Admission	
Inventory turnover rate	6.1 times	5.3 times	
Floor area (central pharmacy)	1623 sq ft	1524 sq ft	
Services offered by over 50% of pharmacies			
Monitoring patient profiles		Monitoring patient profiles	
Monitoring drug interactions		Monitoring drug interactions	
Providing drug information services		Providing drug information services	
Drug therapy consultation		Drug therapy consultation	

teractions showed the largest growth rate during the two-year period 1980–1981, with 87 percent reporting this service in 1981 as compared with just under 83 percent for 1980, which suggests that hospital pharmacists are continuing to expand clinical services.

A comparison of selected operating statistics over the six-year period for which the *Lilly Hospital Pharmacy Survey* has been in existence demonstrates the following trends:

- Pharmacy hours open have risen from 74 to 91 (an increase of 23 percent).
- Pharmacist hours worked per week have increased 71.1 percent (from 152 to 260 hours).
- Technician hours worked per week have varied but have increased overall from 129 to 240 (an 86 percent rise).
- Inventory investment has increased 52.1 percent, and the annual six-year growth rate is 8.7 percent.
- Monies spent on purchases have increased 96.3 percent over the six-year period, with an annual growth rate of 16.1 percent.

The 1982 edition of the *Lilly Hospital Pharmacy Survey* will be distributed in September of this year.

The Center for the Study of Pharmacy and Therapeutics for the Elderly

The School of Pharmacy, University of Maryland at Baltimore, has been instrumental in establishing educational and service programs in geriatrics/gerontology.

It has done so in recognition of the fact that drugs constitute a major disease management modality in long-term care, that elderly receive a disproportionate number of drugs compared to other population segments, and that drugs may also constitute a hazard to elderly if used inappropriately.

Chancellor T. Albert Farmer, M.D., has now approved, on the recommendation of Dean William J. Kinnard, Jr., Ph.D., the formation of the Center, which is a research organization composed of representatives of all departments of the School. Represented are Medicinal Chemistry/Pharmacognosy (Dr. Patrick S. Callery), Pharmacy Practice and Administrative Science (Drs. Robert S. Beardsley and Francis B. Palumbo), Pharmacology and Toxicology (Dr. Myron Weiner), Pharmaceutics (Dr. R. Gary Hollenbeck), Pharmacokinetics (Dr. Lawrence J. Lesko) and Clinical Pharmacy (Dr. Robert J. Michocki). The research center was formed in response to the realization that a dearth of good scientific data on the action of drugs, particularly when they are used chronically, exists and that there is a lack of guidelines for their appropriate use in geriatric medicine. Some specific goals to be addressed:

- The influence of dosage forms on drug action. The need for specific dosage forms for elderly patients.
- The interaction of nutrition and drug action.
- Changing pharmacodynamics and pharmacokinetics with age, and implications of these processes to drug therapy.
- Drug toxicity, adverse drug effects and measures to prevent or ameliorate their effects.
- Development of animal models and analytical methods to study drug action in elderly more efficiently.
- Drug-taking behavior of elderly patients.

Drugs used chronically should be able to delay or at least to diminish the effects of dependency. They must be used so that they do not impact adversely on the elderly patient's mental, functional, nutritional, or physical status. There is therefore, an overriding necessity to develop the scientific and clinical data base so necessary to insure better management of drug use for and by the elderly.

For information, contact Dr. Peter P. Lamy, School of Pharmacy, University of Maryland, Baltimore, Md. 21201 (301/528-7613).

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See also our current listings in the classified ads on page 31.

Procardia® (nifedipine), A Review

by Michael Barletta, Ph.D., R.Ph.
Associate Professor
St. John's College of Pharmacy

Nifedipine (Procardia®, Pfizer Laboratories) is a member of a new class of pharmacological agents, the calcium channel blocking agents, and was approved by the FDA in December, 1981. Animal and human studies have shown that by inhibiting the cellular influx of calcium ions, nifedipine is a potent coronary and peripheral artery vasodilator. This effect results in an increase in coronary artery blood flow to normal as well as ischemic myocardial areas, both during rest and during exercise. Of special therapeutic interest is the high degree of effectiveness of nifedipine in preventing coronary artery spasm, which has been implicated in the etiology of angina pectoris in many patients. In addition to the effects of the coronary vasculature, nifedipine dilates the peripheral arteries, effectively diminishing the afterload pressure against which the heart must work. The net result is a more efficient ventricular emptying and reduced myocardial oxygen requirements, energy consumption, and work. Therefore, nifedipine manages angina by reducing myocardial oxygen demand while increasing oxygen supply by preventing spasm.

The pharmacokinetics of nifedipine have been well described in man. The drug is rapidly absorbed (90%) after oral administration with peak blood levels evident in about 30 minutes. Approximately thirty percent of the drug is excreted unchanged in the urine, and about 75 percent is excreted in the urine as the metabolite. Nifedipine is 90% bound to serum proteins with a plasma half-life of approximately two hours; its therapeutic effect is evident for a duration of up to six hours.

In one study of over 100 patients with Prinzmetal's (or "Variant") angina who were refractory to conventional nitrate and beta-blocker treatment, the sustained effect of nifedipine (40 to 160 mg/day) was to reduce the number of anginal attacks by 53 percent as well as reduce nitroglycerin therapy requirements.

In another well-designed study of stable angina patients with fixed coronary artery disease, nifedipine (30 to 40 mg daily) significantly decreased the incidence of anginal attacks as well as the nitroglycerin dosage by 50 percent. The drug also increased exercise tolerance in these patients and decreased myocardial oxygen consumption.

A double-blind study, using 16-point precordial mapping techniques, showed that a combination of nifedipine (30 to 60 mg daily) and propranolol had enhanced antianginal activity.

The adverse reactions of nifedipine are generally mild. They usually improve with reduction of other antianginal medications. Only about 5% of patients have to be discontinued from the drug. As with other vasodilators, hypotension can occur, especially if the patient is concurrently taking hypotensive agents. The following adverse experiences have been reported: flushing, dizziness, lightheadedness, headache and, rarely, syncope. Peripheral edema, unrelated to congestive failure, which responds favorably to diuretic treatment, may be a consequence of vasodilator therapy. Although some of the other calcium channel blockers have potentially serious problems in concomitant use with beta blockers, only rare reports of congestive heart failure with this combination utilizing nifedipine have ever been reported. Nifedipine may be safely coadministered with nitrates; however, no controlled studies are available which have evaluated the antianginal effectiveness of this combination. Since there have been teratogenic effects in animals at high doses and there are no adequate and well-controlled studies in pregnant women, nifedipine should be used during pregnancy only if the potential benefit justifies the potential risk to the patient.

Although no well-documented evidence of overdosage exists, as expected with other potent vasodilators, significant hypotension could occur. Such a situation would warrant cardiovascular support with vasoconstrictor drug administration.

Nifedipine should be used with caution in the patient with severely impaired liver function, since body clearance may be prolonged. Because the drug is protein bound, dialysis may not be beneficial.

The usual starting dose of nifedipine is 10 mg three times daily with the usual effective dose range of 10 to 20 mg three times daily. However, higher doses (20 to 30 mg three or four times daily) may be necessary to treat patients with coronary artery spasm. Daily doses as high as 120 mg are rarely necessary, while more than 180 mg per day is not recommended. Ideally, dose titration should proceed in a stepwise fashion over a 7- to 14-day period in order to properly assess the response to each dose level and minimize the likelihood of side effects. Blood pressure monitoring should precede each higher dose administration. If symptoms so warrant, and provided that the patient is assessed frequently, more rapid titration regimens may be employed, such as increasing dosage by 10-mg increments (from 10 mg three times daily to 30 mg three times daily) over a three-day period. Very rapid titration regimens are possible under close supervision within the hospital setting. With constant monitoring, the dosage can be increased in 10-mg increments over 4- to 6-hour periods as required to control pain and arrhythmias due to ischemia, with single doses rarely exceeding 30 mg. Unlike the beta blockers, no "rebound" effects have been observed with abrupt discontinuation of nifedipine. However, sound clinical practice suggests that all drugs be gradually discontinued.

In conclusion, nifedipine is a new calcium channel blocking agent which is approved for use in all types of angina. Studies show that it is very effective in chronic stable, vasospastic and mixed angina (combined spasm and fixed lesion). The drug can be employed beneficially together with the conventional agents used in angina such as nitrates and propranolol. Side effects are mild and primarily an extension of vasodilator activity. Nifedipine has no known interaction with other drugs and may be safely administered together with nitrates, beta blockers, digoxin, furosemide, anticoagulants, antihypertensives and antidiabetic agents. The drug is unique in that it represents a new pharmacological class of agents that is a welcome addition to the drug therapy of ischemic cardiovascular disease.

William Grove, Past President of the Maryland Society of Hospital Pharmacists represented the Continuing Education Coordinating Council and Chaired the May 2, 1982, Continuing Education program on "Oncology".

Designated as the AZO Annual Frederick T. Berman Seminar, the program was held at the Quality Inn in Towson Maryland.

Clarence L. Fortner, Director of Clinical Research Pharmacy Service at the Baltimore Cancer Research Program spoke on the "Side Effects of Chemotherapy" at this Council sponsored program.

Baltimore Metropolitan Pharmaceutical Association President Frank Marinelli presided over their meeting held May 19th at the Hilton Hotel in Pikesville. The meeting featured a CECC sponsored program, the "New Drug Road Show."

Jean M. Weis has been assigned to a Baltimore territory for The Upjohn Company. She recently completed four weeks of training at The Upjohn Company Learning Center in Kalamazoo, Michigan.

John Moore has recently graduated from a sales training course for the position of Sales Representative for Burroughs Wellcome Company. He will be working out of the Baltimore area.

Pictures courtesy of District-Paramount Photo

ABSTRACTS

Excerpted from PHARMACEUTICAL TRENDS, published by the St. Louis College of Pharmacy; Byron A. Barnes, Ph.D., Editor and Leonard L. Naeger, Ph.D., Associate Editor

ANTIHYPERTENSIVE THERAPY:

A group of 51 hypertensive patients were placed in a study after their diastolic pressure had been kept below 90 mmHg for a six-month period of time. At that time there was a reduction in their medication, and the patients were continually evaluated for 6 more months. After that initial period, one drug product was eliminated in 38 patients and the dosage of a second drug was reduced in 49 patients. By the end of a year, 13 patients required an increase in their medication to maintain diastolic pressures below 90 mmHg. In general, it is suggested that drug therapy during hypertension be reevaluated periodically in order to reduce the use of unnecessary medication. *J Am Med Assoc,* Vol. 246, #22, p. 2593, 1981.

CEFTIZOXIME:

A new cephalosporin derivative has been found to be effective against infections caused by some Gram negative organisms. It is stable to most beta-lactamases produced by these bacteria and has shown the ability to eradicate infections caused by the indole positive Proteus, Enterobacter, B. fragilis, and S. marcescens. The new agent is bacteriocidal and has only minimal toxicity. Ceftizoxime was synthesized in Japan. *J Clin Pharmacol,* Vol. 21, #8, 9, p. 388, 1981.

TERBUTALINE:

Terbutaline (Brethine) is a beta-2 adrenergic stimulant used to control symptoms of asthma, but it has also been utilized to slow uterine contractions and prevent premature fetal delivery. When used for this purpose, terbutaline enhances cardiac activity to a significant extent. Additionally, patients may develop pulmonary edema. The edema is thought to be associated with increased pulmonary blood flow due to the increased cardiac activity rather than to cardiac failure. Treatment for this complication includes withdrawal of the drug, administration of oxygen, placing the patient in an upright position and utilization of small doses (5 to 10 mg intravenously) of furosemide (Lasix). Symptoms are generally eliminated within 4 hours after initiation of this therapy. *J Am Med Assoc,* Vol. 246, #23, p. 2697, 1981.

MOLINDONE:

Depressed patients refractory to electroconvulsive therapy and tricyclic antidepressant regimens were given either tranylcypromine (Parnate) or molindone (Moban). Molindone in small doses was effective in treating refractory depression and had a faster onset of action than the monoamine oxidase inhibitor. Additionally, molindone is not associated with as many potential interactions as is tranylcypromine. *J Clin Pharmacol,* Vol. 21, #8, 9, p. 351, 1981.

METHICILLIN RESISTANT STAPH:

Since 1961 there have been reports of methicillin-resistant staphylococci appearing throughout the world. Most of the reports of resistance have been taken from records of hospitalized patients, but recent information indicates that these infections are becoming more common in the general population. The community infections are thought to have originated in the hospital setting rather than evolving separately. *Ann Intern Med,* Vol. 96, #1, p. 11, 1982.

BLEOMYCIN AND LUNG FIBROSIS:

Fibrosis of the lung is a complication of bleomycin therapy. In order to determine the origin of this problem, the drug was administered to animals and the progress of the animals monitored from the biochemical standpoint. It was noted that bleomycin induced the lung tissue activity of lysyl oxidase which increased the concentration of hydroxyproline and desmosine in that tissue. These substances lead to an increase in connective tissue rigidity and a reduction in tissue compliance. *J Pharmacol Exp Ther,* Vol. 219, #3, p. 675, 1981.

INSULIN-LIKE GROWTH FACTORS:

There are two substances which have been found in the plasma which contribute to normal growth and development, yet have insulin-like activity. One substance, insulin-like growth factor I (ILGF-1), was found to be deficient in pygmies and in growth hormone deficient patients. These substances apparently also function in the regulation of carbohydrate metabolism. *N Engl J Med,* Vol. 305, #7, p. 965, 1981.

ANTINEOPLASTIC AGENTS:

People who handle and administer antineoplastic agents may have an increased risk of toxicity from these drugs. Pharmacists who prepare solutions of antineoplastic agents were found to have substances in their urine which could cause abnormal cell growth in some in-vitro cell systems. The use of masks and rubber gloves does not seem to help reduce the risk as much as preparing the solutions carefully under a laminar flow hood. Prospective studies will be conducted to determine if those who prepare, administer and handle these solutions may have an increased risk of toxicity. Additionally, since many cytotoxic drugs are excreted in the urine, employees who handle bed pans will also be studied to see if they too are at risk. *J Am Med Assoc,* Vol. 247, #1, p. 11, 1982.

CIS RETINOIC ACID:

Cis retinoic acid has been used topically and systemically for treatment of various dermatological disorders, yet little is known about its metabolic fate in the body. Studies conducted in humans indicate that this congener of vitamin A is metabolized to 4-oxo-13 cis retinoic acid. Several other minor metabolites have also been identified. *Drug Metab Dispos,* Vol. 9, #6, p. 515, 1981.

BOTULINUM TOXIN:

Botulinum toxin is a term used to describe at least eight separate biological substances. One major toxin contains two protein chains which function to bind to tissue and disrupt cellular function. The toxin acts by preventing acetylcholine release. An extensive review of Botulinum toxin has just been published. *Pharmacol Rev,* Vol. 33, #3, p. 155, 1981.

TASTE VARIATION WITH AGE:

Early studies seemed to suggest that the acuity of taste sensations decrease with age. More complex studies using solutions of sodium chloride, citric acid, sucrose, and quinine sulfate indicate that this is true for sensations which detect saltiness and bitterness, but not for those which respond to sweetness or sourness. Patients ranging in age from 23 to 88 years participated in this study. The reduction in sensitivity to saltiness may be the reason some elderly patients use the substance in excessive amounts. *J Am Med Assoc,* Vol. 247, #6, p. 775, 1982.

ANTACID THERAPY:

Patients receiving antacid therapy and/or cimetidine (Tagamet) in efforts to reduce gastric acidity may encounter an increased risk of Gram negative pneumonia. Alkalinization of the stomach allows growth of organisms which will not normally survive the acid pH. These organisms colonize the stomach during periods of alkalinity and can gain access to the respiratory tract. This pneumonia is more common in the severely ill patient. *Lancet,* Vol. I., Vol. 8266, p. 242, 1982.

INTRANASAL INSULIN ADMINISTRATION:

Insulin is injected because it is destroyed by enzymatic action within the gastrointestinal tract. A group of investigators in Italy have used the drug intranasally and have reportedly controlled blood sugar satisfactorily in patients with insulin-dependent diabetes mellitus. The method is said to be both safe and effective. *Br Med J,* Vol. 284, #6312, p. 303, 1982.

OSTEOPOROSIS:

Osteoporosis is most common in post-menopausal women. Various types of therapy have been used to help prevent erosion of bone tissue, but recent studies indicate that perhaps maximal benefit can be obtained using a combination of calcium, fluoride and estrogenic substances. *N Engl J Med,* Vol. 306, #8, p. 446, 1982.

ALCOHOL AND PROPOXYPHENE INTERACTION:

Fatal interactions involving propoxyphene (Darvon) and ethanol constitute the second most common type of ethanol-associated mortality. Propoxyphene does indeed add to the respiratory depression produced by alcohol, but another mechanism may also be involved. Animal experiments indicate that ethanol enhances the absorption of the analgesic thus suggesting that both pharmacological and pharmacokinetic parameters may be associated with this potentiation. *Drug Metab Dispos,* Vol. 10, #1, p. 92, 1982.

FISH FAT:

Studies conducted in people living in areas where fish is the major source of food have shown that there is a lower incidence of atherosclerosis, thrombus formation and myocardial infarction than is found in other areas of the world. It has been postulated that an analog of arachidonic acid, eicosapentaenoic acid (EPA), found in high concentrations in fish, may be responsible for producing the beneficial effects. EPA is incorporated into human platelet lipid membranes in the place of arachidonic acid thus decreasing the amount of thromboxane A-2 which can be formed by the platelet. Since thromboxane A-2 is associated with platelet aggregation and thrombus formation, reducing its activity in these areas may help explain the lower incidence of these cardiovascular complications in patients with high fish intake. *J Am Med Assoc,* Vol. 247, #6, p. 729, 1982.

PHENCYCLIDINE:

Phencyclidine (PCP) is a synthetic substance easily made by amateur chemists with little sophisticated equipment. Law enforcement officers searching for suspected manufacturing areas attempt to locate the site of synthesis by smelling for the solvent used in the preparation of the hallucinogen. Police officers who routinely handle confiscated material have been studied to determine if the substance persists in the body of people who have come in contact with it. Some officers were found to have PCP concentrations in their plasma and urine for at least six months after they had last been in contact with the chemical. The substance is apparently absorbed through the skin and respiratory tract and is only slowly eliminated from the body. *Clin Toxicol,* Vol. 18, #9, p. 1015, 1982.

GALL STONE DISSOLUTION:

Patients with cholesterol-rich gallstones may experience dissolution of the stones while taking chenodeoxycholic acid or ursodeoxycholic acid. This therapy may replace the need for surgery in some patients and is generally preferred by patients. Sixty patients who were found to have responded favorably to this therapy were followed to see if the stones would reform. Approximately half of the group did exhibit recurrence of the stones indicating that long-term follow-up is advisable in order to re-institute therapy if required. *Lancet,* Vol. I, #8265, p. 181, 1982.

HCFA Releases Indicators to Assess Drug Reviews in Long-term Care Facilities

The Health Standards and Quality Bureau has developed guidelines to help surveyors determine compliance with drug regimen review requirements in long-term care facilities.

Medicare and Medicaid regulations require pharmacist or nurse conducted drug reviews in skilled nursing facilities (SNFs), intermediate care facilities (ICFs), and intermediate care facilities for the mentally retarded (ICFs/MR). These requirements have been in effect since 1974.

These reviews entail the examination of a number of documents (e.g., drug administration records, nursing notes, physician orders, laboratory reports, etc.). The information collected from these documents is analyzed by the pharmacist or nurse to determine if there are any potential problems with the patient's drug therapy, and whether drug therapy is achieving the stated objectives established by the physician for that patient. If there are potential problems, and/or if stated objectives are apparently not being achieved, then the attending physician must be notified for whatever action he or she determines is necessary.

Eleven studies conducted by pharmacists have demonstrated the cost reduction potential of drug regimen reviews. The potential comes principally from reductions in drug utilization. For SNF patients this reduction could mean a *net* annual savings of approximately $23 million for the Medicare and Medicaid programs. For ICFs a *net* annual savings of approximately $30 million could be realized from these reviews. No estimates have been calculated for ICFs/MR. These potential cost savings are exclusive of any that result from prevention of hospitalizations resulting from poor drug therapy management. They also do not reflect the potential for quality improvement.

The Indicators consist of six guidelines that will assist State agency long-term care facility surveyors in determining whether a quality drug regimen review has been performed. A summary of the six Indicators is as follows:

1. The number of drug regimen reviews performed must be at or near the average census of the facility in any one month since the regulations require each patient to be reviewed monthly.
2. Drug regimen reviews should be performed in the facility.
3. The average prescription utilization per patient should not be significantly over 6.1. The 6.1 average prescription utilization is the most currently calculated national average for SNF patients.
4. Drug administration errors which can be reasonably identified by the reviewer should be brought to the attention of the director of nursing.
5. Apparent problems in drug therapy such as the need for drug continuance should be brought to the attention of the attending physician.
6. The number of drug therapy problems identified by the pharmacist or nurse should be at least five per 100 patient months of care rendered.

Those interested in the details of each Indicator are urged to obtain a complete copy from Dr. Samuel W. Kidder (FTS 934-1814, or Commercial (301) 594-1814)

If the State agency surveyor finds that a pharmacist or nurse reviewer has not *identified* a potential problem described by the Indicators, and *notified* someone with authority to correct the potential problem, then an indication of poor performance of drug regimen review exists.

Before these Indicators were recommended for adoption, they were tested by the Mississippi State Survey Agency. Eleven health facility surveyors applied them to 29 SNFs. These surveyors rated the usefulness of the Indicators at 7.6 on a 10 point scale. In addition a number of pharmacy, medical, nursing home and consumer groups were consulted before the ''Indicators'' were adopted.

It must be emphasized that the Indicators are not regulations. They are merely surveyor guidelines to be used to determine compliance with the drug regimen review. A long-term care facility cannot be required to comply with any component of the Indicators. However, considerable variance from the Indicators can be a justification for a non-compliance finding relative to the drug regimen review requirement.

Implementation of Indicators is expected to result in better quality drug regimen reviews in long-term care facilities. Enhancement of drug regimen reviews is expected to improve the quality of drug therapy and reduce its costs. The Indicators were effective on April 1, 1982.

Classified Ads

Classified ads are a complimentary service for members.

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WELL-ESTABLISHED, GROWING PHARMACY in Silver Spring area. Contact Mitch Baer at MARK XXI, LTD. (301) 657-9727.

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PROFESSIONAL PHARMACY in Northern Virginia, grossing $400K. Contact Mitch Baer at MARK XXI, LTD. (301) 657-9727.

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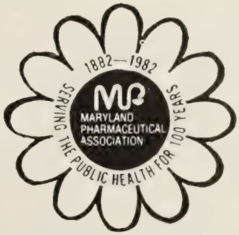
* Each 1982 member of the Association is receiving a special Centennial membership certificate. These certificates are sent at no additional charge as 1982 dues are paid. Contact the office if you have a question about this certificate.

* Special offer. A Mounting and display kit available from the Association for displaying your Centennial Certificate. $15.00 each from the Association office.

* The M.Ph.A. is offering to the public and its members the USP publication, "About your Medicine." This 400 page reference book covers the top 200 commonly used medicines. $4.50 each plus $1.00 for postage etc. from the Association office. Also available—"About your High Blood Pressure Medicine"—$3.00 each plus $1.00 postage and handling.

* The Pharmacy Art Print "Secundem Artem" is available from the Association office. This 18″ × 24″ full color print is only $25.00 plus $3.00 for shipping and handling.

* Centennial Apothecary Jars with the Association's historic banner displayed is available for only $12.00 each which includes handling. Quantity discounts are available and it makes an excellent gift.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An attractive metal pin is available from the Centennial Celebration Committee. This yellow, white, gold and red colored commemorative lapel pin is available from the Association for only $5.00. Proceeds will help fund the activities of the Centennial Committee. Order yours now from the Association office.

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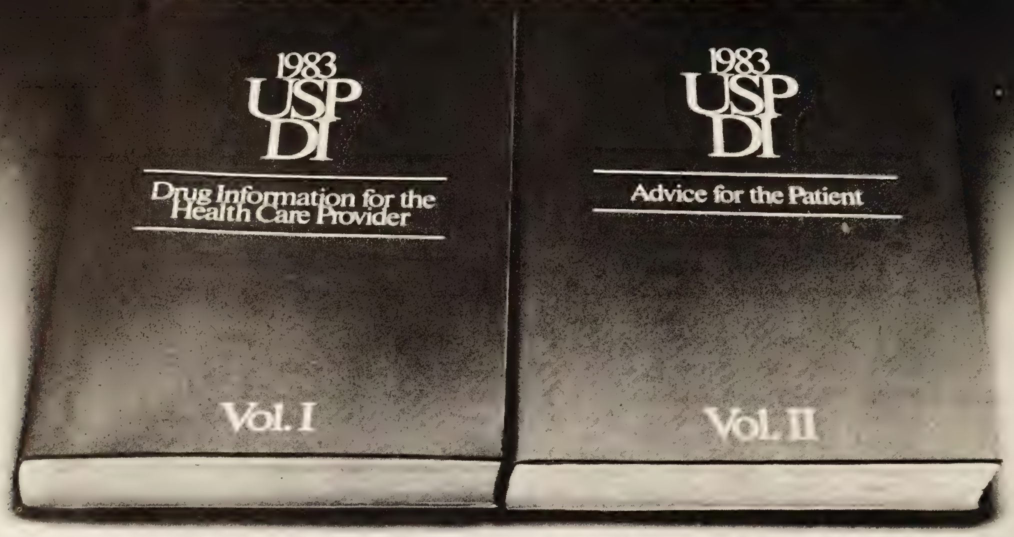

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SERVING THE PUBLIC HEALTH FOR 100 YEARS

Convention Proceedings
Issue

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(These remarks were delivered by President Sappe at the 100th Annual Banquet of the Association, June 22, 1982.)

I would like to thank the Association members for allowing me to become the first President of our new century; a century of vital concern to all of us.

Having been connected with pharmacy for most of my years through working for my dad and later as owner of the pharmacy itself, I have recollections of the Association as an owner oriented society. This is not true today as evidenced by the roll of our Association which consists of 205 owners and 819 non-owners. The independent owners are just one of many specialties in our Association and this is as it should be. The practice of pharmacy is changing. It might be that in the last 10 years, the delivery of our product or service has changed more than in the preceeding 90. There are fewer independents, more chains, third parties, government regulations and intervention, HMO's, Pharm.D. programs, clinical, nursing and home care practice. So many things are changing. I believe the next 10 years will be just as dramatic and will probably set the stage for pharmacy for many years to come.

It is sad but true that where there exists a highly competitive society, only the aggressive and the strong remain. Twenty years ago there seemed to be a small independent pharmacy every few blocks. Many of these have closed never to open again.

Hopefully the independent pharmacies that now remain open are those which have withstood the hardening flame of competition and will form a base whereby independent pharmacy may again grow.

Those of you who are not owners have a different set of problems. In hospitals where our out-patient departments are being closed because of financing and those of you who work for the chains where the corporate heads are looking for higher rates of return, the problem may be loss of jobs or the possibility of replacement by cheaper technical labor.

It will be here under the umbrella of our State Association that we will be able to work together in facing our problems and advancing our profession to its rightful place in the health care delivery system.

The lay public, according to one national poll, already holds pharmacists next to Godliness. It should now be our goal to make sure our sister professions also hold us in the highest esteem.

I am asking all those here to work with me and your Association to make this goal a reality. Thank you.

Milton Sappe
PRESIDENT

NATIONAL ASSOCIATION RETAIL DRU

President Milton Sappe (left) accepts the NARD leadership award from William Hill (right), a member of the Board of Trustees.

1882 — 1982
SERVING THE PUBLIC HEALTH FOR 100 YEARS
MARYLAND PHARMACEUTICAL ASSOCIATION

President's Report to the 100th Annual Convention

Our Association has accomplished a great deal over the past twelve months, and I will discuss much of that in the next few minutes. Our accomplishments for the most part were a result of our Committee's activities so at this time, I commend the unselfish contributions that our committee members have made. When I was sworn in as President of the Maryland Pharmaceutical Association, among other points, I stressed the importance of committees and their role as a mechanism for Association members to affect Association operations. The enthusiastic response by our members to serve on committees has been gratifying. I would like to take the opportunity to thank everyone who participated on MPhA Committees, especially the chairmen. We had thirteen standing and ad hoc committees last year. All of them were active and effective. Many of them had a banner year in terms of meeting and exceeding their goals and expectations. In alphabetical order, I wish to thank our committees for their fine work.

The Awards committee had the unenviable task of recommending from a list of highly qualified nominees two individuals to receive our two official MPhA awards, the Bowl of Hygeia and the MPhA Achievement Award. Joe Dorsch chaired that committee.

We are all familiar with the fine work of Bill Skinner, who has chaired the Centennial Committee for two years. His committee has arranged for a series of events to celebrate the one hundredth year since our Association started. Bill and his committee also developed a variety of commemorative paraphernalia and achieved much positive publicity for pharmacy.

We are here today enjoying the sun of Ocean City, partaking in stimulating professional development programs and deliberating on our future. All this and more was orchestrated by Elwin Alpern and the Convention and Trips Committee. They also arranged for trips to London and Ireland this year as well as an enjoyable evening to Toby's Dinner Theatre in Columbia, Maryland.

Barbara Barron and her committee gave new life to the old Employee/Employer Relations Committee when they restructured the committee as a forum and an ombudsman organization for all pharmacists. They developed an all-inclusive Model Employment Agreement, conducted a survey so that we could better understand ourselves and prepared articles to enhance our professional self-esteem. They are now preparing a policy manual.

Under the leadership of Nick Lykos, the finance and Budget Committee formulated a plan for the financial management of our association, including new sources for non-dues income. Thanks to the work of many pharmacist, this Association is financially healthy and the prognosis for the future looks even better.

1981/82 President Philip Cogan delivers the President's address to the House of Delegates meeting.

Mark Golibart headed the Industry Relations Committee. They focus on resolving issues of common concern to the profession and the drug industry such as improved legibility of labels and expiration dates, return goods policies, Desi Drugs labeled less than effective, OTC reformulation, look alike drugs, unethical marketing practices, and improved communications.

Our Legislative Committee under the able leadership of Milt Sappe did an exemplary job this year. We couldn't do anything wrong. Practically every bill we opposed was defeated and practically every bill we supported, including repeal of the price poster, was passed.

Another dream come true was the results of our Membership Committee's effort. This was a recordbreaking year for the Association over 1025 new members. Frank Blatt and his committee worked hard and we are all grateful for their innovative recruitment approaches.

Irv Kamenetz and his Peer Review Committee were able to equitably resolve to the satisfaction of all concerned allegations of impropriety by a very small minority of pharmacists in this state.

Thanks to Harry Fink our Public Relations Committee chairman and thanks to Phil Weiner who conducted the weekly public service broadcast on WCAO and WXYV radio last year, the public's appreciation of pharmacy is enhanced. Our press releases concerning our Centennial Celebration has brought a great deal of favorable recognition. One year in particular has been the public's enthusiastic response to our distribution of the USP publication, "About your Medicines" drug information for consumers.

President Cogan and family are shown before the Centennial Banquet. (left to right) His mother Marie, wife Cookie and daughter Amy.

The Resolution Committee under the leadership of Jim TerBorg worked diligently to develop and massage the language for the resolutions we will consider at this convention.

Dean Leavett chaired the Scholarship Committee. That Committee screened all the applications for two MPhA scholarship, the Harry David Kaufman and MPhA scholarships and made recommendations for their award.

The Third Party Committee under the leadership of Don Schumer and Jim TerBorg made great strides this year. They have maintained dialogue with the State under very trying and delicate conditions and have suggested several innovative approaches for public and private third party reimbursements programs, incentives for cutting costs, and realistic procedures for those participating in the Medical Assistance program.

In addition to the regular committees, MPhA holds seats on two additional committees and rotates as chairman every few years. These are the Tripartite Committee, consisting of the Professional Association, the School of Pharmacy, MPhA and MSHP. The Tripartite Committee has been quite successful in resolving issues of common concern to the participating organizations such as dealing with the PD designation, the pharmacy curriculum and legislation affecting pharmacy.

The Continuing Education Coordinating Council, chaired by MPhA. Executive Director Dave Banta this year, was extremely successful. Every pharmacist in the State had access to quality continuing education programs. The traveling "New Drug Road Shows" were particularly well received. Over the years, the Council has eliminated poorly scheduled, overlapping programs and has served to bring order to the continuing education programs sponsored by a variety of pharmacy organizations in the State.

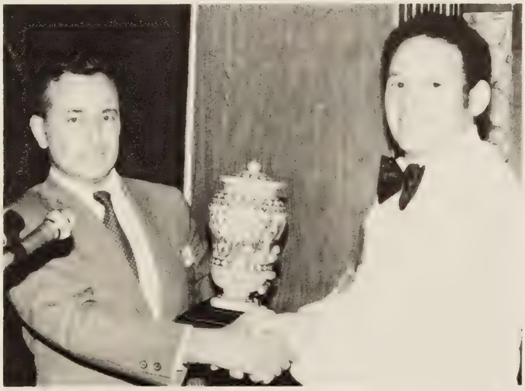
I would be remiss if I did not mention the pharmacist who is personally responsible for keeping us all informed of current events in pharmacy. We all owe a debt of gratitude to Mel Rubin who has done an excellent job in writing our newsletter for several years. As many presidents before me, I have also relied upon him for good advice and counsel. The last person I would like to thank and praise is Dave Banta, our Executive Director. I cannot say enough on his behalf. He is a remarkable administrator, an excellent journalist, and effective lobbyist and a delightful individual.

Unfortunately, the news is not one hundred percent positive. Costs continue to escalate, while third party reimbursements are not keeping pace with inflation. Pharmacy still takes a bad rap for the rise in the price of prescriptions, rules for participation in third party programs are becoming more cumbersome, crimes against pharmacies continue unabated and we are over-regulated.

This year we lost a great pharmacist and a great friend. We will all surely miss pharmacist Victor Morganroth, a past president, a past honorary president and mentor.

One of the things we wanted to do last year was to improve communications; I think we have succeeded. Channels of communications have been opened in every sphere of our Association's interests. I personally visited almost every local association at least once. I represented the Association at the APhA Annual Meeting and I visited related pharmacy associations in the State. Many other individuals represented our interests in dialogue with the State and Federal regulatory agencies, State and Federal legislatures, other professions, consumer groups and industry meetings. We have been an active association and one in which we may all be proud.

Cogan (left) receives the Past Presidents Award from incoming President Milton Sappe (right).



Jack Peters (right) presents Cogan with the E. R. Squibb Past President's Award at the annual Banquet.

The Need for LEADERSHIP

by William S. Apple, Ph.D., President
American Pharmaceutical Association

This Centennial Celebration of the founding of the Maryland Pharmaceutical Association is a source of great pride to the pharmacists of Maryland and to our profession. The fact that your Association and many others have been celebrating the 100th year of their existence is eloquent testimony of the "staying power" not only of the profession itself but also of the organizations pharmacists have created to further the broad-based interests of the profession and to represent it in the community at large.

During the past couple of years, I have had the pleasure of attending several similar observances among your sister state associations and of speaking on many subjects of current concern to pharmacists and to their national professional society, APhA. Let me assure you of my pleasure in learning—upon receipt of your invitation to address this Centennial meeting—that my schedule would permit me to be with you tonight. None of us needs to check our schedules to know we have another commitment at the time the Bicentennial of the Maryland Pharmaceutical Association will be noted.

In recent speeches, I have addressed several topics. Tonight, I want to talk really about only one subject—the one that I see as being of the most critical importance, at least insofar as the future of pharmacy as an organized profession is concerned. My topic is the subject of "leadership".

I would be remiss in discussing leadership were I not to acknowledge the historical fact that the pharmacists of Maryland have placed an important role in the organizational life of APhA. William Proctor—known as "The Father of American Pharmacy"—was born in Baltimore, near the site of your Association headquarters.

Of APhA's founders in 1852, three were Marylanders. No fewer than seven Maryland pharmacists have served as Presidents of APhA, spanning the years from 1857 through 1940. Among the illustrious Maryland names that have figured prominently in APhA were George W. Andrews, a community pharmacist from Baltimore who was elected Vice-President of APhA at its organizational meeting in 1852 and subsequently served as APhA President in 1857; Charles Caspari, Jr., who was Dean of the Maryland College of Pharmacy and who served APhA as its Vice-President in 1892 and following that, for seventeen years, served as APhA General Secretary; Evander F. Kelly, who served as APhA Secretary for almost 20 years from 1925 through 1944; and, of course, Henry A. B. Dunning, who not only served as APhA President in 1930, but who also chaired the committee whose efforts resulted in construction of the present APhA Headquarters building in Washington in 1932. Among the most influential pharmacists in America must be counted Bob Swain who served as APhA President in 1932 and who was the Editor of *Drug Topics* for many years after World War II.

Dr. William S. Apple, President of the American Pharmaceutical Association delivered a special Centennial Address to the Annual Banquet. He is shown here with his daughter Chandra before the start of the Banquet.

APhA was actually headquartered in Baltimore during the term of Charles Caspari as APhA General Secretary from 1894 through 1911. So, the ties between APhA and Maryland pharmacy have been both close and strong.

You will note that in acknowledging the contributions of Maryland pharmacists to our national professional society I have mentioned only several who are no longer with us but whose legacies to the profession live on. I will not even attempt to catalog the numerous Maryland pharmacists who, happily, are still with us and who have contributed their time and their efforts to further the goals of APhA through service on the Association's many committees, as Trustees, and as officers during the Association's modern history.

I also want to acknowledge the foresight of those Maryland pharmacists who initiated and who have supported affiliation of your state association with APhA. The people I could name in these categories—and who are known personally to most of you—should well appreciate what I have to say to you tonight regarding the subject of leadership, for in my experience they have been true leaders of the profession with all the attributes of leadership that are to be admired. We need look no further than to them as role models for the leaders that the profession so desperately needs today and will need tomorrow.

I have served as the Chief Executive Officer of APhA for over twenty years. In this post, I have had an excellent opportunity to observe the development and performance of the profession's leadership cadre during that period. During the first decade of my tenure, I was extremely gratified at the excitement generated among pharmacists and their commitment in not only accepting but seeking and *fulfilling* positions of responsibility in the profession's leadership structure at the national, state, and local organizational levels. Unfortunately, I now look back and must say that this healthy situation peaked around ten years ago, plateaued for a few years, and has since then been on a downhill trend.

I don't mean to suggest that pharmacy organizations have had great difficulty in nominating and electing association officers, directors, and committee and other activity chairmen. I distinguish, however, between holding such a position and functioning as a leader. Leadership requires knowledge, imagination, the ability to think, initiative, and unlimited hard work.

The depressing fact is that many pharmacists who have held organizational positions in recent years served as little more than what I call "letterhead leaders", individuals whose concept of leadership is limited to seeing their names printed on their association's letterhead and whose major goal in organizational life is to collect as many photographs and press clippings as possible of their tenure in office.

. . . many Pharmacists have served . . . as little more than "Letterhead Leaders" . . .

It is apparently difficult for some pharmacists to understand that there is a difference between recognition and leadership. It is my judgment that the profession has suffered a breakdown in its leadership development process, particularly with regard to bringing along a new generation of practitioner leaders. Moreover, the failure of positive leadership influence has been accompanied by an equally serious phenomenon—a rather virulent increase in pharmacy political demagoguery. So there will be no misunderstanding of what I am talking about, let me remind you that the dictionary characterizes the demagogue as one "who makes use of popular prejudices and false claims and promises to gain power".

Our failure to develop real leaders in the profession now combined with a period of severe economic pressures on community practitioners—particularly pharmacy owners—once again focuses our attention on an important lesson of history. When times are hard, people look for scapegoats as a preferable course to subjecting their own behavior to critical analysis and evaluation. Scapegoats are usually those "at the top".

The past year has seen a recurrence of the old NARD refrain that APhA does not represent the interests of community practitioners. In March of this year, the President of the Indiana Pharmacists Association revived the old chant that APhA is simply an organization of educators and scientists. He complained on the editorial page of his Association's journal that APhA "is no longer representative of the pharmacy practitioners of America". He purportedly drew his conclusions from the fact that in the last election for APhA office, there was not a community practitioner among any of the eight candidates.

In my response, I noted that less than five percent of the APhA membership is made up of educators and scientists. I pointed out that this segment of the profession is not only proud to support and contribute to the profession and APhA, the Association is also proud to acknowledge their importance in and to the profession. The fact is that ninety-five percent of the pharmacists who belong to APhA are community and hospital pharmacists. Also, during the last ten years, seventy-two percent of those elected as APhA Trustees were either community or hospital practitioners. I also pointed out—and this lies at the heart of my comments here tonight—that during the two previous years, 1980 and 1981, not a single pharmacist of any category from Indiana had volunteered to be considered for APhA office. I consider this fact an unfortunate blemish on an outstanding Hoosier record of contribution to APhA.

For those who may not immediately recall the fact, let me remind you that APhA members elect the Associaton's official family from among pharmacists who submit their names each year as candidates for APhA elective office. Those who are nominated are owed nothing by the Association and they in turn owe APhA nothing but their dedicated effort to work for the betterment of the Association and the profession.

At APhA, we accept at face value the willingness of volunteers among the membership to make every contribution they can, and we accept their efforts without regard to the particular area within the profession in which any individual is employed. I am pleased to note at this meeting that the Maryland Pharmaceutical Association apparently shares the same philosophy.

As all of you know, Phil Cogan practices administrative pharmacy in the federal government. He was elected and has served as your President this past year because you recognized his leadership ability as he held one position after another in your Association. Phil started demonstrating his leadership potential and commitment to the profession as a SAPhA leader 20 years ago and has been contributing ever since. You can be proud of your not permitting his talent to go to waste.

It is a matter of great concern that some pharmacists who appear to aspire to recognition will not only resort to playing political games to gain attention—and sometimes regard—but also that they are at the same time unwilling to do the hard work that can lead to recognition based on merit rather than political strategy and tactics.

There has been a great deal of discussion in our society of the current quest for instant gratification in social and work environments. People don't want to work their way to the top; they want to be dropped there by helicopter. When it comes to making a contribution, however, there is no substitute for experience. A pharmacist who has worked on behalf of a county association will be a more effective worker for a state association. And, a person who has served a meaningful "internship" in a state association's committee or officer structure will be a more productive committee member or officer of a national pharmacy organization.

There simply must be a way to involve in pharmacy organization work more pharmacists who are willing to give in order to get. In short, the profession desperately requires a revival of its past ability to develop pharmacy leaders with the capacity and willingness to make substantive contributions to the profession. We need new people who will be remembered after their service as more than a name on a letterhead or a face in a picture.

The profession has serious problems to address and it requires leadership to address them. Let me speak for a few moments about one of our overriding problems.

It may shock you to learn that I believe the most serious of our problems are created within the profession itself rather than among the many stresses and strains that are imposed by outside forces. It has been too easy, particularly during the last several years, for pharmacists to lay the blame for the profession's difficulties at everyone's doorstep but their own. But the fact is, my colleagues, we pharmacists bear a substantial responsibility for having created and now sustaining our own problems.

Despite the fact that many in pharmacy have a clear vision of where the profession must proceed in its development as a health care calling, and despite the fact that many individual pharmacists have been doing as much as they can to futher their role in the health care system and in serving the public, the bulk of our practitioners simply have not done enough—in their own interest as well as the public interest—to take advantage of opportunities to provide sound professional and economic underpinnings for their practices. Let me illustrate.

In 1970, APhA commenced its battle on behalf of the profession to replace fifty state antisubstitution laws with pharmacist authority to engage in drug product selection. It is not necessary for me to review in detail the history of the drug product selection effort. Let me just recall for you several salient points.

First, APhA sought drug product selection authority for pharmacists so that pharmacists could function as thinking health practitioners rather than as robots in a distribution cycle.

Second, APhA sought drug product selection for the economic benefit of self-paying patients and the taxpayers as well as to improve pharmacy practice economics.

Third, APhA's position on drug product selection was initially vigorously opposed by several pharmacy organizations and most pharmacists. By the time pharmacists recognized the significance of the opportunity and gave their political support to the required state legislative efforts, consumer and other interest groups had preempted pharmacy's leadership role.

If pharmacy had moved swiftly and forcefully in the very early 1970s, we could have had the onerous antisubstitution laws repealed instead of replaced. Because we lacked in quality, quantity, and unity of leadership, the profession has again been saddled with restrictive and unworkable bureaucratic procedures. The sad fact is that the American people now believe that they have restored the pharmacists' privilege and responsibility to be their purchasing agents for prescription drug products, and the public now is holding pharmacists accountable for not performing on their behalf.

While the current situation is not ideal, there is still time for pharmacists to improve their standing with the public. It will mean investing time and effort educating both prescribers and patients in who and why they should utilize the pharmacists' procurement expertise.

In another area related to economics, I am bitterly disappointed in the failure of practitioners to take advantage of another opportunity offered by APhA. APhA invested in the development of the Uniform Cost Accounting System for pharmacies to improve their economic circumstances through implementing tighter and more efficient management controls. Independent experts in the field have evaluated UCAS as an excellent management information tool capable of being understood and effectively utilized by pharmacy practitioners. But, the number of pharmacists who have availed themselves of the opportunity even to examine UCAS is pitifully small.

Apparently, some practitioners are going to be content only to expect their associations to wave a magic wand that will assure their professional success. For such pharmacists, apparently a good many, the perceived road to economic salvation is to follow the pied pipers in pharmacy and their bewitching tales of antitrust law exemptions for collective bargaining, pharmacist unions, and self-ordained fancy titles.

For those who are inclined to place their hop and bet their future on the preposterous schemes of some pharmacy organizations and some individuals in the profession, I would remind you of the observation offered by the genius of the automobile industry, Henry Ford, to the effect that "A man does not make his reputation on what he promises."

Pharmacy is not going to get by on promises. Pharmacy is not going to get by on self-protective laws and regulations. And, my colleagues, pharmacy is not going to get by on naive wishful thinking. There is only one salvation for the profession and its practitioners and that salvation lies in establishing a level of public confidence that pharmacists are acting both fairly and responsibly in the public interest as well as their own.

A recent Gallup Poll tells us that, right now, pharmacists are held in very high public esteem where questions of ethics and integrity are involved. What would a similar poll focusing on pharmacists' professional competence and performacne reveal? It is up to each pharmacist on a one-to-one basis to establish the kind of relationship with his or her patients that will lead to the overall level of confidence that I am convinced is absolutely necessary for us to look to future professional and economic rewards. And to reemphasize my theme regarding the need to develop new pharmacy leadership, I believe that it is in this most critical area of professional performance that real leadership in pharmacy is most desperately required.

Pharmacy organizations can provide opportunities, but only individual practitioners can take advantage of these opportunities and transform them into such rewards.

. . . Only one salvation for the profession . . . lies in establishing a level of public confidence . . .

Over the years, as I have illustrated, APhA has sought to provide such opportunities for the profession. Most recently, the Association successfully lead opposition to the FDA mandatory patient package insert program. Did it do so because the Association is opposed to patient education or because it believes that patients should not have more information regarding the appropriate and effective use of drugs dispensed by pharmacists? Anyone who knows of APhA's commitment of time and money to patient education—such as development of the Health Education Center Service in the early 1960's would dismiss such negative motivation out of hand.

No, ladies and gentlemen, the Association's position and the criticism that it had endured for not going along, even from respected figures in American pharmacy, was based on the desire to preserve a professional role for the pharmacist in patient consultation and education, to prevent the pharmacist from being forced into a role of file clerk and paper-pusher, and to preserve for the pharmacist a *professional* role with both health care and economic value to the public—a role for which the pharmacist would ultimately be compensated in recognition of its value.

APhA is not wedded to dogma and its members, speaking through the Association's House of Delegates, do not develop its policies out of fear or concern for how others in or out of pharmacy may react to them. Nonetheless, for years the Association has been forced to protect its flanks and its rear from the incessant sniping of organizational and individual pharmacist demagogues.

After more than thiry-five years in association work, I am well aware that it is impossible to please everyone with regard to any given issue—no matter what position or action is taken with regard to the matter by any association. Some members will always disagree with what has been proposed or done and, frankly, that fact neither surprises nor offends me. Nor should it surprise or offend anyone else in pharmacy. If APhA takes pride in any one of its achievements, it takes pride in the fact that the Association operates as a democratic forum in which all voices and segments of the profession may be heard. After all, dissent and debate are what democracy is all about.

On the other hand, no one can take pride in the kind of demagoguery to which I have earlier referred. It should be exposed and condemned in the strongest terms when it occurs. Such appeals to prejudice and fear contribute nothing beneficial to the profession; they damage not just those attacked but the profession as a whole. Moreover, such tactics are usually nothing more than a smokescreen resorted to by those who have no accomplishments of their own to crow about.

As a result of my long experience in association work, there are certain truths that I know exist. One of these is that when old problems are resolved, new problems will surface to take their place. Another truth is that there has been and will be no hiatus for the profession when it comes to opportunities that must be seized. Another truth is that as pharmacy's leadership corps and capabilities are diminished, the difficulty which the profession will experience in addressing both problems and opportunities will increase. We simply cannot let that happen.

The American Indian culture admonishes each of us not to criticize another until we have walked a mile in his moccasins. I admire that principle, and I urge each of you and your colleagues to "walk" before you "talk". Do your walking up front as a leader in the profession whether it is only in your community or whether it reflects your commitment to assisting your profession at the state or national level.

And, my colleagues, give an enduring meaning to your leadership commitment. Reach out to the younger members of the profession and bring them along with you. Help them to understand the profession's need for their contribution and the value that we place on their involvement in our organizational endeavors. In so doing, you will write an indelible record of giving to our profession.

The noted journalist Walker Lippman, soon after the death of Franklin D. Roosevelt, created an epitaph to which each of us can and should aspire. Lippman said:

> "The final test of a leader is that he leaves behind him in other men the conviction and the will to carry on."

As individuals and as a profession, I can think of no finer legacy than that kind of leadership for us to leave many generations of pharmacists who will step into our shoes and continue the profession's march to the future.

The Maryland Pharmaceutical Association can be proud of everything it has accomplished during the past hundred years. It will accomplish even more in the next century of its history if Maryland pharmacists more vigorously pursue the advice they received a third of a century ago from their own Bob Swain:

> ". . . it is within our power to make tomorrow what we want it to be, provided we want it hard enough and are willing to work for it with every resource of heart and mind which we individually, and as a profession undoubtedly possess."

Thank you.

CORRECTIONS—In the June issue of the *Maryland Pharmacist* we inadvertently published a rough draft of a letter from Alumni Association President Angelo Voxakis, instead of his finished letter. We regret the error and apologize for any inconvenience.

LAMPA Celebrates

LAMPA President Betty Alpern (right) presents Josephine Spigelmire with the LAMPA Honorary President Certificate for Centennial year.

The annual LAMPA Brunch experienced an unusually high turnout.

LAMPA LOU
Lounge Donat
LAMPA LA
1982

LAMPA President Betty Alpern presents Executive Director David Banta with a plaque to be hung in the Kelly Building designating the lower level of the structure as the "LAMPA Lounge" in recognition of their restoration efforts.

Pictures Courtesy of District/Paramount Photo

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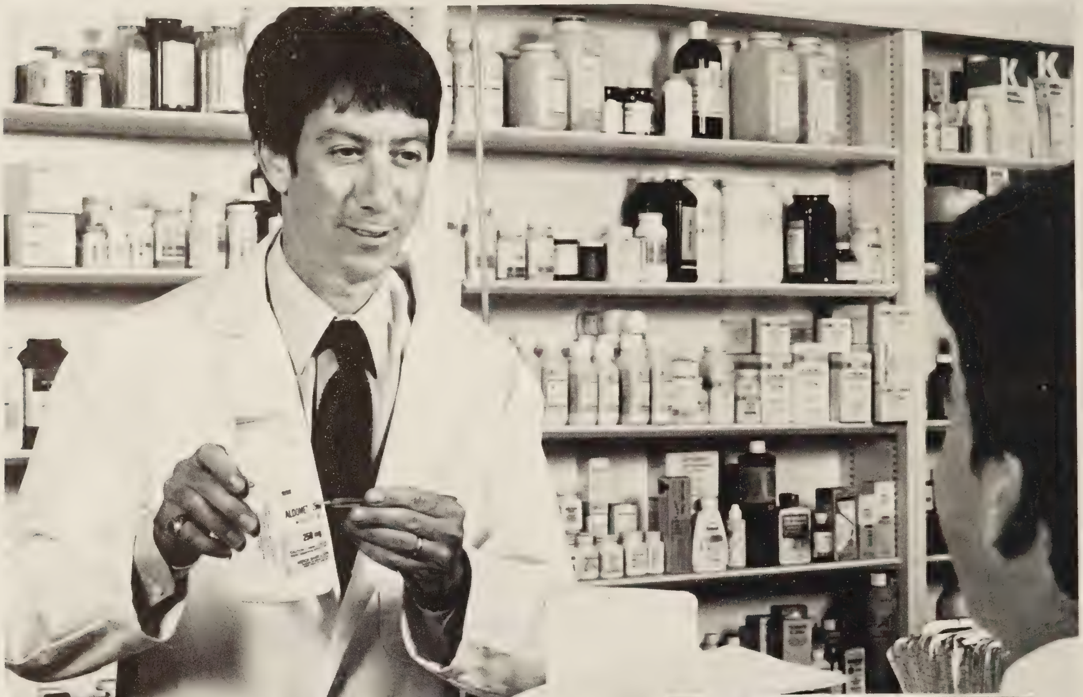

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ANNUAL REPORT
OF THE
MARYLAND BOARD OF PHARMACY
1981–1982

In compliance with the provisions as set forth in the Health Occupations Article Section 12-205 of the Annotated Code of Maryland, this report is submitted to the Honorable Harry Hughes, Governor of Maryland and to the Maryland Pharmaceutical Association. This is the seventy-nineth report to the Governor and the sixth-nineth report to the Association. The report covers the activities of the Maryland Board of Pharmacy for the fiscal year ending June 30, 1982. This report is also being submitted to the Secretary of Health and Mental Hygiene, the McKeldin Library of the University of Maryland, the Enoch Pratt Free Library, the Department of Legislative Reference, the Hall of Records, and the State Library.

MEETINGS

During the year the Board held nineteen meetings, seven of which were held at the School of Pharmacy of the University of Maryland, for the purpose of conducting examinations for registration of pharmacists.

OFFICERS

Bernard Lachman was elected President and Paul Freiman was elected Secretary-Treasurer of the Board.

PERSONNEL

Roslyn Scheer is the Administrator, Margaret Lloyd is the Office-Clerk I and Sandra Kimble-El is the Steno Clerk III.

EXAMINATION

The Board conducted examinations for registration of pharmacists during the fiscal year. They were held at the School of Pharmacy of the University of Maryland on June 23, 24, 25, and 26, 1981 and January 26, 27, and 28, 1982.

The applicants who were examined in June of 1981 were licensed in July 1981 which is in F.Y. 1982. There were one hundred and thirteen applicants for the Board in June, 1981. Eighty-six passed both the theoretical and practical portions of the examination and were subsequently registered. Twenty-four failed the examination. Having previously passed the practical portion of the examination, three candidates took the theoretical examination in June. The candidates passed and were subsequently registered.

There were twenty-five applicants for the Board in January, 1982 (F.Y. 82). Nine passed both the theoretical and practical portions of the examination and were subsequently registered. Twelve failed the examination. Having previously passed portions of the examination, four candidates took the practical examination, passed and were subsequently registered.

Data relative to the June 1982 examination will be given in the next Annual Report.

The Standard Examination of the National Association of Boards of Pharmacy was given, which consisted of the following subjects:

- Chemistry
- Pharmacy
- Mathematics
- Pharmacology
- Practice of Pharmacy
- Laboratory
- Jurisprudence

The Jurisprudence examination included the Federal Law Exam and the Maryland Law Exam. The Maryland Law Exam was compiled by a member of the Board and was given as a part of the practical portion of the examination, as well as the compounding of three prescriptions per applicant. The following table shows the number of pharmacists who were registered by examination during the past ten years:

Year	Number of Pharmacists
1972–1973	96
1973–1974	111
1974–1975	113
1975–1976	109
1976–1977	166
1977–1978	150
1979–1980	180
1980–1981	183
1981–1982	100

As in the past, many pharmacists applied for reciprocal registration in Maryland in order to accept positions with their employers who are opening stores in Maryland. Those applicants who did not meet our requirements concerning practical experience prior to or after registration in another state were advised that they must take our practical examination in order to verify their qualifications.

In all cases an applicant for reciprocal registration must appear for a personal interview. The entire Board must act on whether or not to grant registration to such applicants, who must sign an agreement to comply with Maryland's law pertaining to drugs and pharmacy.

The following table shows the number of pharmacists granted registration by reciprocity and the number who were certified to register by reciprocity in other states during the past ten years.

Fiscal Year	Reciprocity	Certification
1972–1973	94	57
1973–1974	88	63
1974–1975	76	45
1975–1976	89	44
1976–1977	78	68
1977–1978	91	77
1978–1979	113	42
1979–1980	73	69
1980–1981	88	72
1981–1982	85	51
Total		

Paul Freiman, Secretary of the Maryland Board of Pharmacy delivers the annual report to the Maryland Pharmaceutical Association House of Delegates as specified by law.

The table shows Maryland gained 34 pharmacists by reciprocity during the past ten years.

New permits to operate a pharmacy were issued to 44 firms for the 1982 Fiscal Year.

PHARMACY PERMITS

Location	1981–1982
Counties:	
Anne Arundel	3
Baltimore	10
Carroll	4
Charles	2
Garrett	4
Harford	3
Kent	2
Montgomery	3
Prince Georges	4
County Totals	35
Baltimore City	9
State-Wide Totals	44

MANUFACTURERS' PERMITS

New permits to manufacture drugs, medicines, toilet articles, dentrifices, or cosmetics during 1981 were issued to one firm.

DANGEROUS DRUG DISTRIBUTORS' PERMITS

The Board issued four new permits to sell, distribute, give or in any way dispose of dangerous drugs during 1981.

OTHER PERMITS

The total number of pharmacies in the State of Maryland for 1982 fiscal year is 918 and the total number of pharmacists in 5,060.

LEGISLATION

The following legislation which effects the profession of pharmacy either directly or indirectly was enacted by the 1982 Maryland General Assembly.

List of Bills that were enacted during the 1981 Legislative Session and their purpose as it pertains to pharmacy.

New Laws Effective July 1, 1982

SB 280 - Pharmacists - Licenses - For - License Renewal - Reinstatement of Expired Licenses—
Changes examination fee to $85 (actual cost of examination). Allows Board to renew pharmacist licenses in both odd and even numbered years. Allows the Board to adopt rules and regulations governing reinstatement of pharmacists licenses.

HB201 - Drug Formulary of Equivalent Drug Products—
Provides for the automatic listing in Maryland's Drug Formulary of all drugs that meet FDA's standards for approval as safe, effective and determined to be therapeutically equivalent.

HB423 - Board of Pharmacy Licenses—
Allows the Board to adopt rules and regulations governing reinstatement of pharmacists' licenses and to set a reinstatement fee.

HB642 - Health Occupation Boards and Commissions - Licenses, Permit, and Certification Renewal Fees—
Standardized the renewal fees for all Boards within the Health Department. Fees for pharmacist license, pharmacy permit, manufacturer permit and distributors permit are equivalent to $25 a year.

HB1170 - Prescription Drugs - Required Information—
Prescription price posters are no longer required in pharmacies. Instead the pharmacist is required to provide the current price of any prescription to the customer in person or by telephone.

DISCIPLINARY ACTIVITIES

The Board of Pharmacy receives complaints from the public concerning problems with the Board's licenses. For the period of April 1981 to April of 1982 complaints were received. There was a wide range of complaints which varied in severity. Listed below are statistics concerning the types of consumer complaints.

miscellaneous—3rd party complaints	11
miscellaneous*	26
mislabeled prescription	9
communication	11
incorrect drug dispensed	18
homeopattrie pharmacy	1
expiration date	7
generic substitution	5
refilling prescription without authorization	2
infrequently prescribed drug—hard to find	2

* Complaints are on pricing, cleanliness, professionalism—such as pharmacist feeling prescription is a forgery but refuses to check with physician, refusal to transfer prescriptions legal drugs

Other complaints were received from the Division of Drug Control, Medical Assistance Compliance Administration, and the State of Maryland Courts. Six formal disciplinary hearings were held. Four pharmacists licenses were suspended. Two pharmacists' licenses were revoked. Three of the suspensions were immediately stayed and the individuals placed on probation under certain conditions.

COOPERATIVE ACTIVITIES

The Board maintained membership in the National Association of Boards of Pharmacy. The annual meeting of the Association was held in Minneapolis, Minnesota on May 17th–May 20th 1982. The Board was represented by Drs. Bernard Lachman, Paul Freiman, Leonard DeMino, and Robert E. Snyder.

The Board also maintained membership in the Conference of Boards and Colleges of Pharmacy of the National Association of Boards of Pharmacy, District Number Two, comprised of the states of New York, New Jersey, Pennsylvania, Delaware, Maryland, the District of Columbia, Virginia and West Virginia.

The Board maintained cooperative activities with the State Department of Health and Mental Hygiene, the School of Pharmacy—University of Maryland, the Maryland Pharmaceutical Association, the Federal Drug Administration, the Food and Drug Administration, City, County and State Police and all Boards and Pharmacy Schools throughout the country.

FINANCES

All funds of the Board of Pharmacy are deposited to the credit of the Treasurer of the State of Maryland and the disbursements covering the expenses of the Board are paid by voucher by the State Comptroller.

FINANCIAL STATEMENT

The Board of Pharmacy had revenues of $31,120 in 1980 and $97,671 in 1981. The Board of Pharmacy had expenditures of $52,020 in 1980 and $71,992 in 1981. The Board's budget is $63,749 for 1982 and $76,235 for 1983. Due to the passage of HB642, the Department of Health and Mental Hygiene has proposed a supplemental budget for 1983 of $32,092. Total budget $108,327—which will include a full time administrator and another secretary.

OTHER ACTIVITIES

In addition to the President Bernard Lachman and Secretary Paul Freiman, the Board consists of the following commissioners: Ralph Quarles, Robert Snyder, Leonard DeMino, Anthony Padussis, Estelle Cohne, and Phyllis Trump. All the Commissioners are registered pharmacists in the State of Maryland with the exception of Ms. Cohen and Ms. Trump who are consumer (public) members of the Board. Since the last Annual Report, the Board promulgated the following regulations:

1. Regulation to prevent returning to pharmacist's stock any medication once it is dispensed except under certain conditions;
2. Regulation requiring every prescription to be recorded with date of filling or refilling and pharmacist responsible for filling or refilling prescription; and
3. Regulation setting reciprocity fee at $100.

At this time the Board has submitted the following regulations:

1. Regulation to set degree of fines upon disciplinary action of Board of Pharmacy;
2. Regulation to declare undated prescription items on pharmacy shelves to be declared outdated and subject to removal.

In 1982, the Board continued its excellent relationships with the Department of Health and Mental Hygiene. The cooperation and courtesy extended to the Board of Pharmacy by all members of the Department is appreciated by all the Board members.

This year saw the finalization of the transfer of Division of Drug Control to Regulatory Services. Dr. Tregoe has developed a mechanism of operation that the Board believes will assure the public of Maryland greater safety and protection in the use of their medication wherever it is purchased or dispensed. The Board will monitor the new operation to assure its success in meeting this goal.

Again the Board must commend our administrator, Roslyn Scheer for her continued excellent management of the Board's daily business. Through her efforts the Board continues to operate smoothly and efficiently. In addition, the Secretary must commend both of our excellent secretaries Sandra Kimbel-El and Margaret Lloyd for their excellent work and cooperation.

In addition to the items as stated, the Board participated in many activities too numerous to mention. All of the Commissioners actively participated by serving on various committees appointed by the President, attending numerous meetings throughout the State, and being available for consultations and special meetings when necessary.

Respectfully submitted,
Paul Freiman
Secretary-Treasurer

Congratulations from MSHP

On behalf of the members and the Board of Directors of the Maryland Society of Hospital Pharmacists, I extend congratulations on your 100th Anniversary of the founding of the Maryland Pharmaceutical Association. The efforts you have made to mark this occasion, culminating a century of dedication to the profession and to the patients to whom you serve, deserve special recognition, and you are to be congratulated.

This legacy of growth and dedication to the profession has also created a challenge and a responsibility to you, as you begin your second century; a challenge to respond to the forces which influence the profession, and a responsibility to respond in such a manner that delegates to the 200th Annual Meeting of the Maryland Pharmaceutical Association will be able to look back at 1982 and recognize that not only was a chronologic milestone reached, but also a professional one. As you take your first steps into your new century, do so with the realization that the future of pharmacy depends on the directions that you take today.

As I complete my term of office as President of the Maryland Society of Hospital Pharmacists, I look back over the year at the degree of communication and cooperation which occurred between the Society and the Association as a highlight of my term, particularly in the joint efforts on behalf of the Continuing Education Coordinating Council. I look forward to continued joint efforts between the MSHP and MPhA in such matters as continuing education, legislation and other matters of professional concern.

Again, the Maryland Society of Hospital Pharmacists congratulates you on this special occasion, and looks forward to having you share in the celebration of our 100th Anniversary (in 2044!).

Sincerely,
William R. Grove, M.S.
President

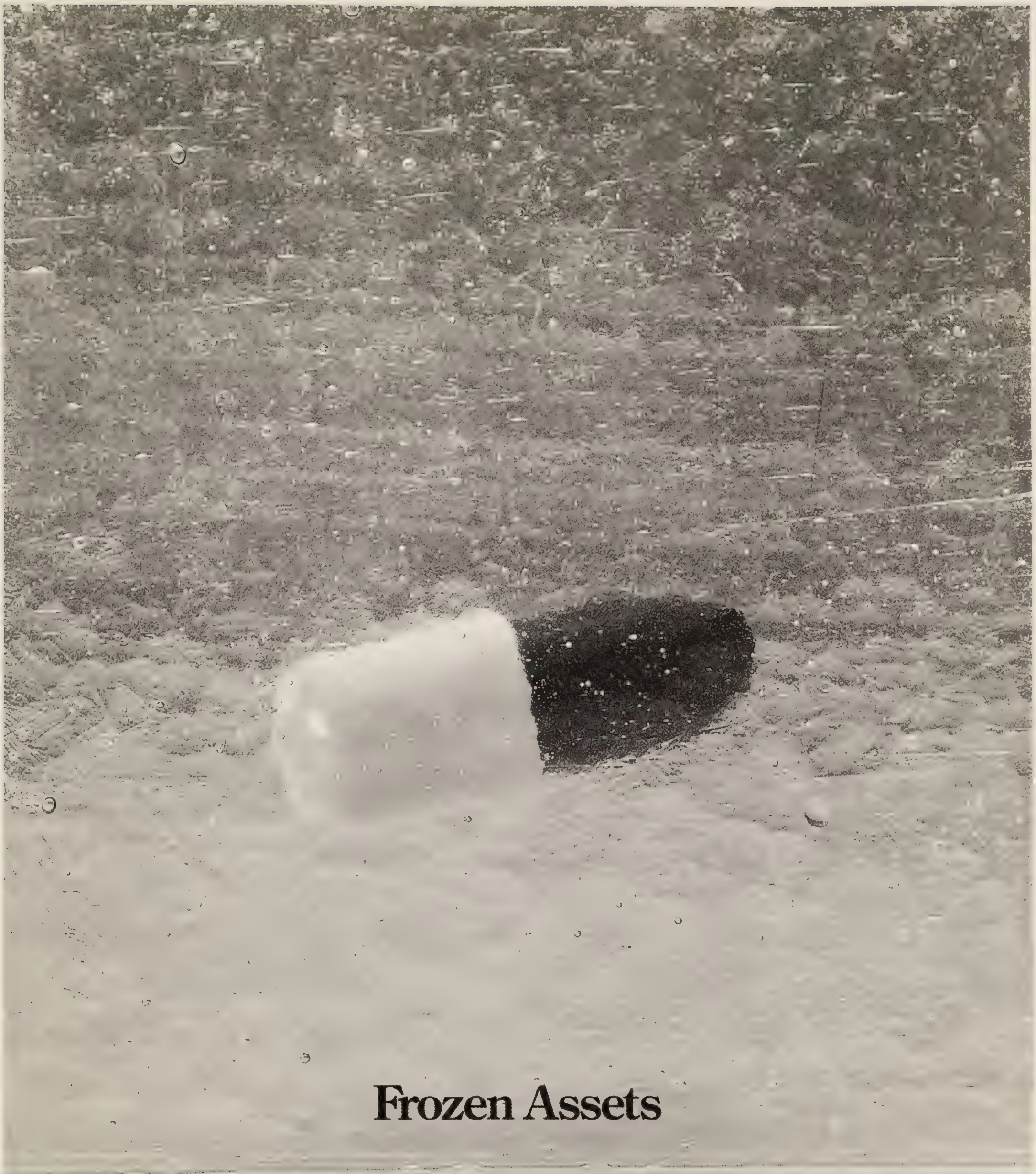
calendar

OCT 10-14 — NARD CONVENTION, BOSTON

OCT 17 (SUNDAY) — MPhA DINNER THEATRE, BURN BRA-MUSIC MAN

NOV 4-7 — SAPhA REGIONAL CONVENTION, BALTIMORE

NOV 14 — ALUMNI ASSOCIATION DINNER MEETING



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Resolutions Considered at the 100th Annual Convention House of Delegates Meeting

1982 RESOLUTION #1

WHEREAS, the name of the Maryland Pharmaceutical Association has often been misleading to those not familiar with the state professional society of pharmacists because the name "Pharmaceutical" has been confused with manufacturing, wholesaling or other outside interest; and
WHEREAS, the Maryland Pharmaceutical Association is beginning a second century of service to pharmacists and the public health and it is appropriate to clearly define the nature and identity of this organization;
THEREFORE BE IT RESOLVED, that the name of the Maryland Pharmaceutical Association be changed to the "Maryland Pharmacists Association" as we begin our next one hundred years; and
BE IT FURTHER RESOLVED, that consistent with the prudent use of existing supplies, that this changeover to the new name be conducted as expeditiously as possible.

(Resolution Defeated)

1982 RESOLUTION #2

WHEREAS, the Maryland Pharmaceutical is concerned that mentally or physically impaired pharmacists receive professional assistance and be prevented from posing a hazzard to the public health; and
WHEREAS, the Association is in a good position to provide peer support and coordination of activities with regard to alcoholic or drug dependent pharmacists;
THEREFORE BE IT RESOLVED, that the Association form a "Rehabilitation Committee" to study methods for detection, counseling and support services for chemically impaired pharmacists.

(Resolution Adopted)

1982 RESOLUTION #3

WHEREAS, the Centennial of the Maryland Pharmaceutical Association is a special event of historic significance; and
WHEREAS, the Maryland Historical Society is the repository of many of the historical documents and artifacts of the State of Maryland;
BE IT RESOLVED, that the list of registrants at the 100th Annual Meeting, a list of the membership, and other appropriate materials, be placed with the Maryland Historical Society.

(Resolution Adopted)

1982 RESOLUTION #4

WHEREAS, the U.S.P. has evolved into a compendia of high utility to the pharmaceutical industry but of reduced utility to the practicing pharmacists; and
WHEREAS, the U.S.P. Dispensing Information has been developed as a resource for practicing pharmacist;
BE IT RESOLVED, that the Maryland Pharmaceutical Association would support a change in the pharmacy law to repeal the requirement of having A U.S.P. in every licensed pharmacy and replace it with a requirement that every pharmacy have a current edition of the U.S.P. Dispensing Information.

(Referred back to the Board of Trustees for study)

1982 RESOLUTION #5

WHEREAS, the armed robbery of Pharmacies is a major threat to the lives of practicing pharmacists; and
WHEREAS, there are before the Congress several bills addressing the problem of armed robberies of controlled substances which should have as much grass roots support as possible; and
WHEREAS, the Maryland Pharmaceutical Association is strongly convinced that mandatory sentencing would be a strong deterrent to such crime;
THEREFORE BE IT RESOLVED, that the Maryland Pharmaceutical Association urges mandatory sentences for persons convicted of armed robbery involving controlled substances.

(Resolution Adopted)

1982 RESOLUTION #6

WHEREAS, the Surgeon General has determined that smoking is hazardous to your health; and
WHEREAS, the Pharmacy profession is committed to the general health and well-being of their patients;
BE IT RESOLVED, that the Maryland Pharmaceutical Association urge their members to refrain from selling tobacco products in their pharmacies and make available educational materials on the hazards of smoking.

(Resolution Defeated)

1982 RESOLUTION 7

WHEREAS, the Maryland Pharmaceutical Association and the University of Maryland School of Pharmacy have enjoyed a long and fruitful Association; and

WHEREAS, the Maryland Pharmaceutical Association is celebrating its Centennial Celebration; and
WHEREAS, the Maryland School of Pharmacy is celebrating the opening of their new building;
BE IT RESOLVED, that the Board of Trustees of The Association investigate the commissioning of an appropriate plaque or other contribution to the School commemorating these two unique celebrations.

(Resolution Adopted)

1982 RESOLUTION
(Proposed from the floor)

WHEREAS, the continuing spiraling cost of medication is a growing concern to the profession of Pharmacy;
WHEREAS, pharmacists have been placed in the forefront of the blame for these increases, even though they have no control over them at all; and
WHEREAS, one 3rd party program has decided to restrict freedom of choice using as an excuse, the refusal of pharmacists to use generic drugs, thus choosing to ignore the real causes of this inflationary spiral;
NOW, THEREFORE BE IT RESOLVED, that the Maryland Pharmaceutical Association immediately convene a conference of all those involved in the distribution and payment for medication. This conference should include representatives from 3rd party providers, other health profession organizations, and manufacturers, so that effective action may be taken by all concerned to help alleviate this situation, and also be it resolved that the press be invited to attend the conference, and notified of our concern and the efforts of this association and its members to meet that concern.

Respectfully submitted,
Paul Freiman, P.D.

(Resolution Adopted)

A MOTION PROPOSED FROM THE FLOOR

I MOVE THAT the Association create a Memorial honoring the outstanding dedication, support and guidance to this Association and its members from Victor Morgenroth, Jr.;
ALSO I MOVE THAT a letter be sent to his widow expressing our condolences at his loss.

Respectfully submitted,
S. Ben Friedman, P.D.

(Motion Passed)

James TerBorg delivers the report of the Third Party Committee and the Resolutions Committee.

MPhA's Third Party Committee Report to House of Delegates

On December 10, 1980 then Chairman Doctor Don Schumer called a meeting of the Maryland Pharmaceutical Associations Third Party Committee. At the time the "Georgia Bill" was before the Maryland legislature, the PharmPAC suit had just been dismissed by the federal court and an upcoming survey of pharmacy dispensing costs was coming from the state medicaid program. Issues of great concern all to even the most apathetic of pharmacists. Indeed these subjects were the motivation for all who attended the meeting. The decision to not refile the suit, the completion of the survey and the need for further study of the "Georgia Bill" settled these issues over the course of the following months. I accepted the co-chairmanship of this committee because I shared with you a feeling of righteous indignation towards third party administrators and their dealings with us. I also realized that change in this area would be a slow process. Although my indignation remains at a healthy level, accepting the sobering reality of the time consumed in bringing about change has been a real challenge.

It was the stated objective of the committee to relieve the Board of Trustees of the task of initiating efforts in third party related matters by submitting specific proposals for approval then following through. The committee was to serve as a structure for dealing with ongoing problems as well as acting as a "crisis intervention team" if the need arose. The committee would also serve as a communications center for members with questions or problems related to third parties. The committee did serve as intended on the first two points but made little headway establishing itself as a third party communications center. No members, in fact, actually requested such service for whatever reason.

It would please the committee to announce model contracts with all third party plans including the acceptance of usual and customary charges. There are other illusions the committee would be happy to report but, alas, they remain just that—illusions. Our accomplishments are in terms of steps not in finished products. The state will give us this July a thirty cent increase in the medical assistance fee bringing to a total of a dollar in increases since the last fee survey was taken. This has come about in no small part because of the untiring efforts of Dave Banta, Doctors Schumer, Rubin and others who continuously meet with state officials to present pharmacy's case. The initiative of Dr. Bookoff in offering an incentive program and Dr's. Sanford and Schumer offering a manufacturer's rebate program to medical assistance typifies the basic give and take (mostly give) that is the cornerstone of our dealing with third parties. If successful at the state level the committee will be going to private plans with similar suggestions—ones very fair to pharmacists and offering substantial savings to the plans. Only time and continued diligent effort will tell. Would you like to know more details about any of the above mentioned projects? Call us at 727-0746 or catch us at Ocean City.

My personal thanks to Doctors Brown, Lichtman, Zucker, Powell and Leo as well as those mentioned above for their participation this past year.

Thank you,
James Louis TerBorg, P.D.
Don Schumer, P.D.

Centenni
Banque

The Officers and Trustees of the Association are shown shortly after installation. They are: (left to right) Philip Cogan, Chairman of the Board; William J. Kinnard Jr., Honorary President; William Hill, Vice President; David Banta, Executive Director; Melvin Rubin, Treasurer; George Voxakis, Trustee; Barbara Barron, Trustee; Milton Sappe, President (and captain of the ship); Ronald Sanford, Trustee; James TerBorg, Trustee; Cheryl Betz, SAPhA; Stanton Brown, Speaker of the House; Harry Hamet, Vice Speaker of the House and Charles Spigelmire, the Installing Officer.

George Voxakis served as Toastmaster for the Centennial Banquet.

Morris Cooper (left) was this year's recipient of the M.Ph.A. Distinguished Achievement Award for his contributions in maintaining the B. Olive Cole Pharmacy Museum in the Kelly Building as its Curator. Cogan presents the Award.

Mike Hickey from the Kerr Glass Company (left) presents President Cogan with a special Award on the Occasion of the Centennial Celebration.

Mark Golibart (left) representing Abbott Labs, and also Chairman of the Association's Industry Relations Committee, presents President Cogan with his Company's Award for the Centennial.

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ictures

All Convention Pictures Courtesy of
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The 1982/83 Honorary President William J. Kinnard, Jr., Dean of the School of Pharmacy, receives his award from President Cogan at Annual Banquet.

Richard Plotkin, representing the Geigy Co. presents Cookie Cogan with the "Pharmacists Mate" Award.

Sam Goldstein (right) receives this year's Bowl of Hygeia Award for his community service work with the Elder Ed Program and other activities from A. H. Robins Company representative Ray Langston.

"Raining on his Parade." Ronald Sanford got wet when the air-conditioner above the podium sprung a leak in the middle of his report. House of Delegates Parlimentarian Donald Fedder attempts to help out (right).

Frank X. Radigan from Merck, Sharp and Dhome presents his Company's Award to the President Cogan on the occasion of the Centennial Celebration.

Employer/Employee Relations Forum Report

The Employer/Employee Relations Committee was reactivated this year after several years of inactivity.

The first act of the committee was to change the name from the Employer/Employee Relations Committee to the Employer/Employee Relations Forum so as to better represent the role of this group.

The first task undertaken by the Forum was to compile a Model Employment Agreement that was later published in the journal. This document was felt to be of great value to both employers and employees and offered many suggestions for consideration of employment.

The most important assignment was to complete a document urging the use, in all pharmacies, of a Policy Manual, and to compile suggested topics that should be covered in an effort to establish a guideline for pharmacists in this state wishing to implement a policy manual.

This group has been very active throughout this year, and its members have met regularly. I would like to take this opportunity to thank all the members of this Forum and the Executive Secretary of the Maryland Pharmaceutical Association for their dedicated efforts and hard work. Much has been accomplished this year, but there is also much left to be completed.

Barbara C. Barron
Chairman

Industry Relations Committee Report

First I want to thank all of the Committee members who took time from their practices and busy schedules to serve with me on this Committee. I feel we accomplished a lot. The Committee continued projects related to return goods policies of manufacturers. The model policy adopted by the Committee and the Association was published in the *Maryland Pharmacist.* The Committee surveyed manufacturers for a list of their representatives in Maryland, a list of toll-free numbers available to pharmacists and a copy of their return goods policies.

The Committee collected samples of unreadable expiration dates which were forwarded to the A.Ph.A. for their meeting with the OTC manufacturers. The subject of unreadable expiration dates was suggested by the Committee for that meeting. The Committee was concerned about OTC reformulation without notice to the Pharmacist. A survey was conducted of OTC manufacturers and the results published in the *Maryland Pharmacist.* The Committee also published the Manufacturer Disclosure List which appeared in California for the information of the members. The Committee met with a clinical pharmacist to discuss new ways that pharmacists and manufacturers can communicate with one another as the practice of pharmacy evolves.

Most recently, the Committee has discussed the rising cost of drug products. We anticipate that this subject will be one of our main focuses as we move into the second century.

Mark Golibart
Chairman

Barbara Barron, Chairman of the Employer/Employee Relations Forum, delivers her Committee's Report to the House.

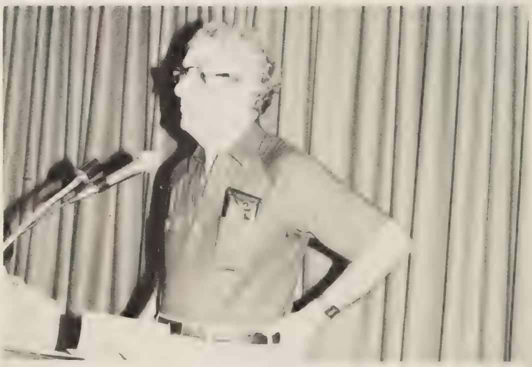
Peer Review Committee Report

The Peer Review Committee is alive and well!!! Over the past year it has continued its main function; that is, to investigate and answer any complaints about pharmacy and pharmacists. Most letters reflected the public confidence in pharmacists; they were astounded that a pharmacist could make an error in dispensing medication. When there was a miscount in the number of tablets dispensed, the complaintant assumed it was a deliberate policy of the chain drug store.

We had an unusual complaint this year . . . one pharmacist complaining about the action of another pharmacist. A competitor was accused of mislabeling a prescription with the brand name instead of the generic name, thereby getting an economic advantage. We settled amicably, the way disputes between pharmacists should be settled. We would like the Peer review Committee to continue being a forum to settle such intra-pharmacist disputes.

It is most important that the Peer Review Committee continue to answer promptly any letter of complaint directed to the Maryland Pharmaceutical Association.

Irvin Kamenetz, P.D.
Chairman



Irvin Kamenetz, Chairman of the Peer Review Committee, answered many questions regarding the work of the Committee over the past year. Watch for more detailed reports in future issues of the *Maryland Pharmacist.*

Centennial Celebration Committee Report

It is my pleasure, on behalf of each member and helper to this Committee, to tell you that most of our plans are on schedule, during this, our Centennial year—1982. Those plans were finalized during the last annual meeting and subsequently presented to your officers and Board for review.

Let me just review for you what we have done in 1982 and what we have to do during the remainder of the year. But let me preface these remarks to explain that your Committee decided to direct most of its Centennial energies toward getting each of you involved in the celebration. We decided not to purchase a lot of souvenirs and trinkets, only a few to give each pharmacist the opportunity to have a memento to help share the memories. We decided to emphasize the past accomplishments of Maryland pharmacists through articles in the *Maryland Pharmacist* and not by elaborate books that might put us in debt.

We decided to use 1982 to launch greater efforts to tell the general public of Maryland what it is we can do for health care during the next 100 years and you will be hearing more about this later.

During 1982, we have thus far kicked off our celebration by recognition from the Baltimore Metropolitan Pharmaceutical Association at its February Dinner-Dance. BMPA President Frank Marinelli presented a recognition plaque to MPhA President Philip Cogan and your chairman sketched the 100 years of history of service to the public health as a solid foundation upon which to build and a heritage which we must constantly live up to.

Following the kickoff event, we have focused attention on the centennial at the Spring Regional Meeting as we will at each of the upcoming state events throughout the year. During the Spring Regional Meeting Issues Forum, we dedicated a new sign on the lawn of the Kelly Memorial Building to announce the visiting policy of the Olive Cole Pharmacy Museum. Thanks to Executive Director David Banta, all of the necessary clearances were obtained from the University and the sign was ordered and placed. David tells me that our sign has evoked only favorable response from the association's neighbors and it has led to a number of inquiries about the museum.

Further, we dedicated a plaque to the memory of two of our towering pharmacy fathers who made an impact on our profession. The plaque can be seen in the association office now, but will soon be properly placed in the museum to acknowledge our gratefulness to Dr. David Stewart and Dr. William Proctor.

Stewart—a pharmacist, physician, educator, school board member, a state senator, city councilman and scientist—gave Maryland Pharmacists an enormous example and model to pattern their careers upon. If our profession only had ten more leaders like Stewart today, we would probably be taking more active roles in attempting to solve our problems now facing us.

Proctor, a native of Baltimore, became an apprentice apothecary and learned the profession in Philadelphia, he later became the professor of pharmacy at the Philadelphia College of Pharmacy, editor of journals, leader in the American Pharmaceutical Association and the beloved, respected and venerated stateman of the profession who was dubbed "The Father of American Pharmacy" by his contemporaries. Naturally if every educator in our school of pharmacy worked as diligently and practically as did Proctor, our pharmacists of today would be well prepared to face our current challenges.

William Skinner, (right) Chairman of the Centennial Celebration Committee receives a surprise award from President Cogan in recognition of his hard work in planning the many activities of the Centennial year.

I urge each of you to learn more about these two men of Maryland's past and pattern your future professional direction to correspond to theirs. The profession will benefit in my opinion, and you will personally benefit as well.

A special work of thanks is due to President Phil Cogan and about a dozen unnamed students of pharmacy who contributed a day or two to help us wax, polish and dust the basement museum room in preparation for the Spring Regional Meeting.

Our students can always be counted on in a pinch and we appreciate even their anonymous assistance.

This brings us to the present meeting to which your committee has provided considerable input in developing program and souvenirs. Rather than list each event the Centennial Committee has developed or arranged, we will ask you merely to compare this meeting with those you have attended in previous years. If at the conclusion of the meeting you think we have made a difference, then I hope you will thank each of the Committee members you see listed at the end of this report.

But what of the months to come? What plans have we made and how will you participate in them?

A special effort has been planned to enlist a number of the Association members in an Association Speakers Bureau. Combining the resources of the Student CODAE and ElderEd Program with some forthcoming speech materials and news releases from the USP, the Association will shortly announce the availability of volunteer speakers for schools, civil clubs, PTAs and other private or public groups.

The reason for the speakers bureau effort is to dramatize the pharmacy profession's abilities to further aid the public's general and specific understanding of drug use. This effort at this point is only a well reasoned suggestion of your Centennial Celebration Committee. What remains to be done is for us to identify where this effort will be supported by you in a conscientious manner.

To make a real impact on the public, volunteers should stand ready to make a minimum of two speeches, using and adapting the materials supplied by the Association. Here is the plan.

The Association will prepare and forward a general announcement of the speakers bureau plan to all local newspapers and school systems. The announcement will suggest that groups wanting speakers will contact the Association office. At that point, we must match the request with a speaker so that date arrangements may be made with the requestor.

Sign up sheets for the Centennial Speaker Bureau are available at the Convention tables and at the Baltimore office. Signing up for this job does not preclude your doing whatever public speaking you may now be engaged in; we do not want to switch your allegiance or loyalty from SCODAE or ElderEd if that is where you are now spending your voluntary efforts. Please continue these.

We believe the materials that are to be supplied to all of the Speakers Bureau volunteers will help you immeasurably. If you have some ideas about speaking and want to incorporate them into our plans, we certainly wish to hear from you.

The Fall Regional Meeting will once again give us an opportunity to emphasize the Centennial.

Let me close my remarks by asking each pharmacist and each spouse to participate in our Centennial. Do this by your active attendance throughout the year, by your participation in the speakers bureau, in the sale of the USP drug information books and by the purchase of our Centennial Jars and Lapel Pins. It has been my pleasure to serve as your Centennial Chairman and I eagerly look forward to each of you taking part in the next 100 years.

Committee Members
Benjamin Allen
Philip Cogan
Morris Cooper
Dudley Demarest, Jr.
Mattie Feinberg
Ronald Lubman
Bennie Owens
Richard Parker
Stephen Provenza
Melvin Rubin
Roberta Van Duzer
William Skinner, Chairman

Students on Clean-up
Terry Davis
Dudley Demarest, Jr.
Vicky Hale
Bill Noonan
Brian Sanderoff
Taher Sheybani
Jane Stahovec

Membership Committee Report

	As of 6/11/81	6/11/82
TOTAL MEMBERS TO DATE:	859	1024
NEW MEMBERS TO DATE:	68	219

COMPARISON:	
MEMBERS TO DATE:	+165
NEW MEMBERS TO DATE:	+151

BREAKDOWN:	6/11/81	6/11/82	Comparison
Owner-Manager	205	205	0
Non-Owner	340	464	+124
Pledge—1st year	62	53	−9
2nd year	50	45	−5
Hospital	34	37	+3
Graduate	9	5	− −4
Retired	68	81	+13
Non-Resident	44	88	+44
Joint	6	7	+1
Associate	41	39	−2
	859	1024	+165

I would like to extend my fullest appreciation to the membership committee for their time and efforts this year. The statistics show that we are prospering even in a period of economic strife. I would also like to invite new volunteers to be a part of this committee. A few hours a year spent in any committee work really gives one a sense of great accomplishment.

I would also like to extend by fullest appreciation to David Banta and his staff for all the extra efforts they have contributed.

Frank Blatt
Chairman

(More Reports coming in the September issue)

SPEAKER'S
BUREAU

MPhA Speakers Bureau is formed

At the 1982 Centennial Convention, the Association kicked off the MPhA Speakers Bureau. Newsreleases have been sent out and a brochure describing this service will be prepared. The June issue of the *Maryland Pharmacist* carries speaker outlines for your use. **Sign up now to participate.** Send the form below to the MPhA office, 650 W. Lombard Street, Baltimore, Maryland 21201.

Name ______________________________
Address ____________________________
City ____________________ Zip __________
Phone ______________ (h) ______________ (b)

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M AND S

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484-7000

Please contact me. I am interested in receiving more information about the Mayer and Steinberg/MPhA Workmen's Compensation Program. ☐ Call ☐ Write.

name

firm

address state zip

telephone #

Thanks, Philadelphia College of Pharmacy and Science

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Many of them were impressed—and said so—with the hundreds of steps and precautions taken to assure a top-quality product.

We were impressed, too—with them.

They were bright, curious, professional and very excited about their careers.

It was a good day. And one way we know of starting—and keeping—a dialogue.

ABBOTT

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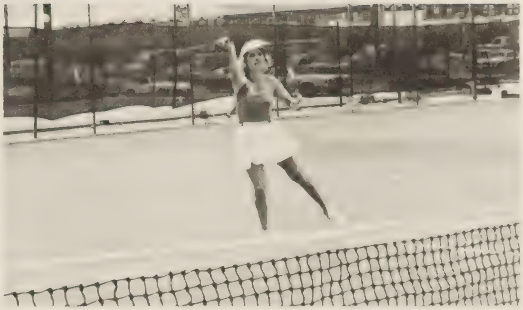
Harles Cone was Spell-binding.



Big Swinger at the Tennis Tournament.

"three different cocktail parties!"

Learning the basics at the Square Dance.

"O.K.—Has anyone seen the fashion show?"

Waiting for Crabs.

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ABSTRACTS

Excerpted from PHARMACEUTICAL TRENDS, published by the St. Louis College of Pharmacy; Byron A. Barnes, Ph.D., Editor and Leonard L. Naeger, Ph.D., Associate Editor

CIMETIDINE:

Cimetidine (Tagamet) has been used extensively for several years, and thus drug interactions involving this H-2 antagonist are being reported more frequently. The alkalinization of the stomach seems to interfere with the absorption of certain drugs which require acid media for solubilization. The absorption of aspirin, and ketoconazole is decreased by half in the presence of this drug. Cimetadine has also been found to inhibit the metabolism of warfarin, the benzodiazepines, phenytoin, theophylline, and carbamazepine. These occur to different extents and are apparently due to the ability of cimetidine to interfere with the heme-moiety of cytochrome P-450. Additionally, a single dose of cimetidine reduces hepatic blood flow, thus increasing the plasma concentration of drugs which are usually removed by first pass metabolism. Drugs which may accumulate via this mechanism include propranolol and labetalol. *Clin Pharmacokinet,* Vol. 7, #1, p. 23, 1982.

ACID SECRETION:

Prostaglandins have a considerable effect on the activity of the gastrointestinal tract. Studies now show that prostaglandin E-2 secreted directly at the site in the stomach plays a major role in regulation (inhibitory influence) of parietal cell acid secretion. Aspirin inhibits prostaglandin synthesis at the site by interfering with cyclo-oxygenase activity thus reducing the concentration of prostaglandin E-2 and allowing for increased acid secretion. *J Pharmacol Exp Ther,* Vol. 220, #2, p. 371, 1982.

LIPOSOMAL ENTRAPMENT:

Drugs can be emulsified with certain combinations of fatty substances so as to put the drug in the core of the fatty preparation. This essentially isolates the drug thus reducing its toxicity when it is administered. In order to be effective, the protective fatty barrier must be removed at the point destined to be the site of action of the drug. Cytosine arabinoside, a potent antineoplastic agent, was placed in such a liposomal preparation. Injections of the preparation were made into the peritoneal cavities of patients with certain types of cancer. The lymph vessels in that area pick up the entrapped antineoplastic agent and transport it to the lymph nodes where the fatty layer is stripped away. This technique may be useful in preventing spread of metastatic cancers which spread via lymphatic pathways. *Drug Metab Dispos,* Vol. 10, #1, p. 40, 1982.

CYCLOPHOSPHAMIDE:

The plasma levels of certain drugs can be determined by measuring the concentration of the drug in the saliva. A technique utilizing mass spectrometry has proven valuable in determining the concentration of the antineoplastic agent, cyclophosphamide, without resorting to invasive techniques. Patient acceptance and comfort is greater with this procedure. *J Clin Pharmacol,* Vol. 21, #11, p. 461, 1982.

TRIMETHOPRIM:

Prior to the introduction of trimethoprim (Proloprim, Trimpex) to the United States market as a single drug entity, some investigators had claimed it was as effective by itself as was the combination of it and sulfamethazole (Bactrim, Septra). Others claimed the combination was an excellent example of pharmacological potentiation produced by using two drugs which affect consecutive pathways in biochemical sequences. Reports from Europe had indicated that resistance readily developed to trimethoprim, but some in this country doubted those reports. Recent evidence indicates that resistance does indeed develop to the use of trimethoprim alone. Studies conducted in patients taking the drug for a two week period of time while traveling in Mexico showed that E. coli organisms especially have a remarkable capacity for developing resistance to this antibiotic. *N Engl J Med,* Vol. 306, #3, p. 130, 1982.

WEIGHT LOSS:

Balloons were placed into the stomach of five obese women and then were inflated with a catheter and left to float about freely in the organ. While inflated, the balloon produced a feeling of satiety and the patient lost weight because of reduced food intake. When the balloon became deflated, it passed out uneventfully with the stool. Before this method can be more universally used, a balloon resistant to acid needs to be perfected. *Lancet,* Vol. I, #8265, p. 198, 1982.

THEOPHYLLINE BIOAVAILABILITY:

Bioavailability of theophylline preparations can vary extensively from product to product and thus many brands cannot be interchanged indiscriminantly. Two brand name products were examined in asthmatic patients to see if variation exists in response to these formulations. Results indicated that Elixophyllin SR capsules and TheoDur tablets produced comparable results with respect to bioavailability, efficacy, and tolerance. *Clin Ther,* Vol. 4, #4, p. 252, 1982.

Dave Schmidt and Harles Cone, Ph.D., teach you how to improve your professional image, interpersonal relations, communications, how to understand, and even predict human behavior. We call it Professional Development and consider it of great value to the pharmacy profession. The Upjohn Company is proud to have been a pioneer in bringing these Professional Development Programs to pharmacy. During the past 8 years, Dave, Harles and others have presented scores of seminars for over 27,000 pharmacists. Perhaps you were among them.

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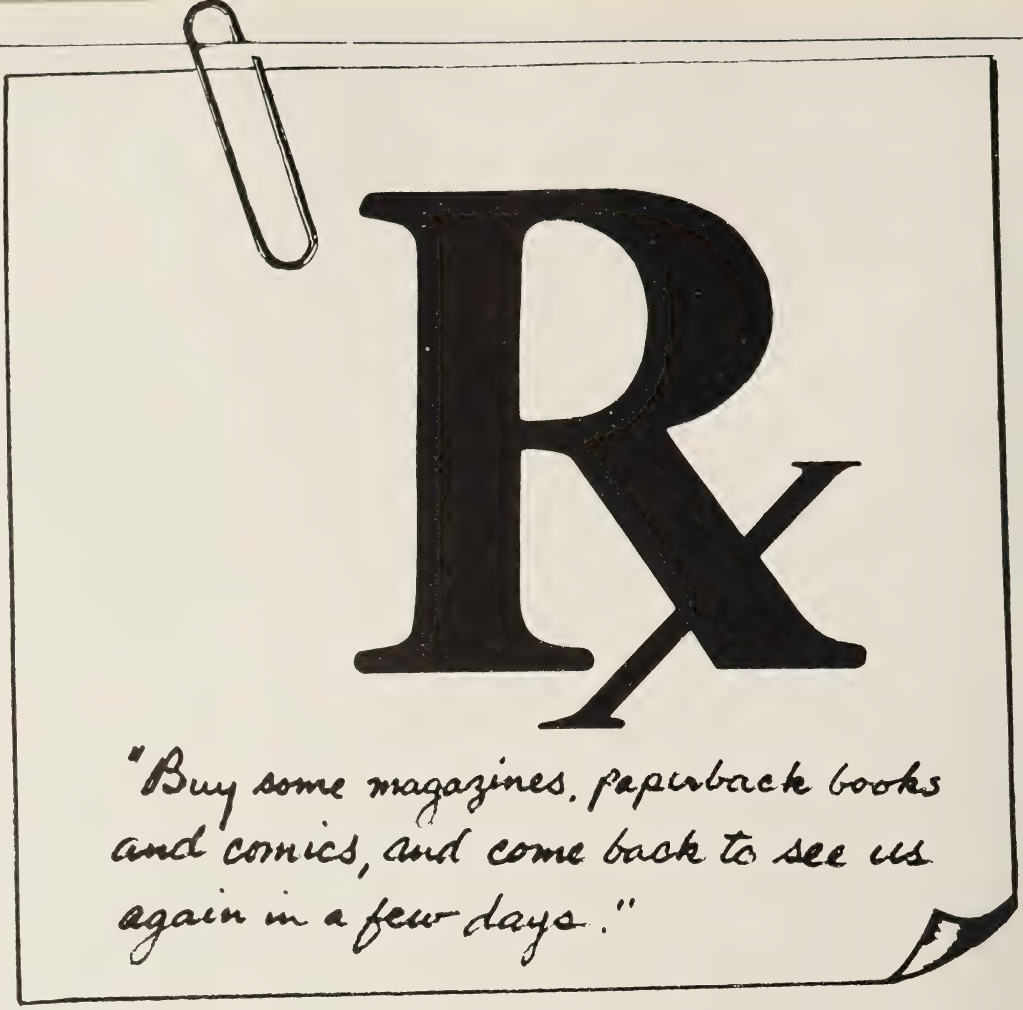
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WANTED TO BUY—Pharmacy, Baltimore area—at least volume of $500,000 annually. Contact: Box 101, Association Office.

Professional pharmacy for sale, includes living quarters, very good opportunity and investment. Call Ed Balcerzak, 433-7572.

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POSITION DESIRED

Pharmacist seeking employment in local pharmacy. Please write or call John J. Selak, 216 Hickory Drive, Fayetteville, Pa. 17222 or call 717-352-2619.

PHARMACY FOR SALE

Ideal location on corner lot, downtown Bel Air. Modern brick building, 8474 sq. ft. floor space on two floors. Owner will sell real estate, business, inventory and equipment. Priced to sell. Worth looking into. Contact Chas. V. Spalding, Realtor, at 879-2500.

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* Each 1982 member of the Association is receiving a special Centennial membership certificate. These certificates are sent at no additional charge as 1982 dues are paid. Contact the office if you have a question about this certificate.

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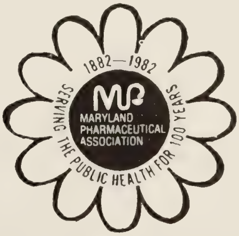
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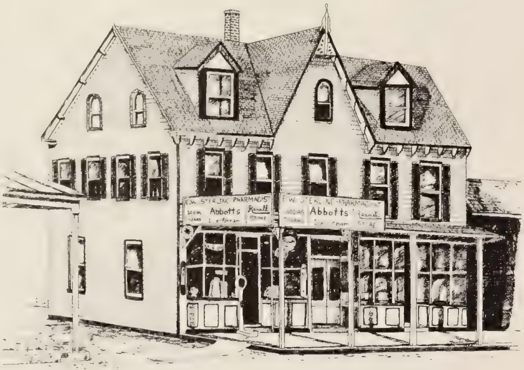
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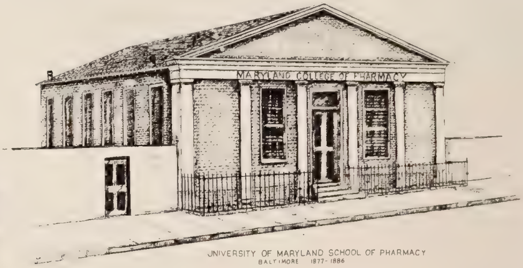
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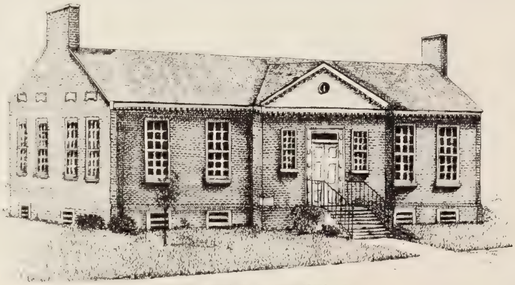

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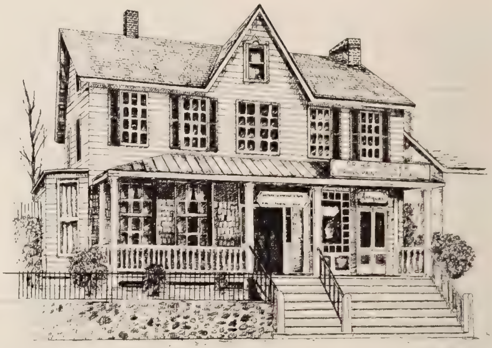

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THE
MARYLAND
PHARMACIST
Official Journal of
The Maryland
Pharmaceutical
Association

September, 1982
VOL. 58
NO. 9

MPhA Testifies Before Congress

Etymology of Medical Terminology

— Stephen J. Provenza, Phar. D.

ASCP's Statement on Pharmacy Education

— Jerome L. Fine, M.S., P.D.

More Convention Reports

THE MARYLAND PHARMACIST

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SEPTEMBER 1982 **VOL. 58** **NO. 9**

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Blocadren, Calan, Dolobid, Feldene, Midamor, Oraflex, Procardia, etc., etc.—all new drugs. All are in stock either because they were received on automatic shipment or ordered through our wholesale salesman. We received the package inserts, the usual accompanying literature, postal and periodical advertisements. But where was the manufacturers representative? It was only in the case of Oraflex that we saw a representative from one of the major drug manufacturers. Speaking now as community pharmacy owner, I often wonder if physicians are asked as many questions as we are in direct conversation with the patient or later on the phone. I take this as great complement to our profession. Granted, a large percentage of the questions are answered through common sense, but others more complicated, may mean placing the patient on hold and looking up the appropriate information. Yes, I try to read the inserts, the incoming mail and anything else available, but if you are like me, the mail and reading matter piles up. Much of my education is reactionary. In other words, it is a direct result of a patient's question.

Major drug manufacturers are my biggest problem in this area, especially with their automatic shipments. There does not seem to be any personal follow-up. The manufacturers have enormous amounts of money to spend on development, detailing, sampling and promotional literature, and yet so little time to see me and those like me who are on the very edge of patient care. I realize that the prescription originates in the doctor's office and because huge amounts of money are needed to deliver a new drug to the market place, an economic factor is involved, but what about patient care? Manufacturers are responsible for this valuable information and for ensuring that it is adequately disseminated to all health care providers, especially in the case of new drug entities. I realize that it will be said that some pharmacists will not take the time to see detail persons, but this is not a new charge. Physicians are guilty of this also. It seems to boil down to that bottom line. Yet is not some regard due to patient care. In today's environment, with all of the new drugs coming onto the market and all the new drug being tested and used abroad, it is imperative that the dispensing community pharmacist be given information promptly and concisely so that the patient may best be served.

Milton Sappe,
PRESIDENT

MPhA Testifies Before Congress On Pharmacy Burglaries

Mr. Chairman and members of the Committee, I am David Banta, Executive Director of the Maryland Pharmaceutical Association. The Association is the state-wide professional society of pharmacists in Maryland with over 1000 members. I appreciate this opportunity to appear before the Subcommittee on Criminal law to testify in support of bills dealing with the increasing problem of pharmacy robberies.

On April 7, 1982, the pharmacy community in Maryland was again rocked by the newspaper headlines that another of our colleagues had been senselessly shot and critically wounded during a burglary of his pharmacy. Pharmacist Robert Kantorski was working in his pharmacy, the Ritchie Prescription Pharmacy in Brooklyn Park Maryland, when two armed robbers demanded drugs. Mr. Kantorski was complying with their orders when he was shot three times. This kind of irrational violence has become all too familiar to Maryland Pharmacists.

Several months ago, The Village Pharmacy in Gaithersburg, Maryland was robbed by an armed female who held the pharmacist at gun point while a clerk gathered the powerful narcotic, Dilaudid, which the robber demanded.

The McAlpine Pharmacy in Ellicott City, Maryland was also the recent target of an armed hold-up. The two robbers held the pharmacist and store employees at gunpoint while searching for drugs. They ignored the money in the cash register and took only the drugs they were seeking.

Pharmacists in Maryland remember the death of Pharmacist David McLarty who was gunned down in his Linthicum Pharmacy by robbers after the narcotic drugs in Pharmacy.

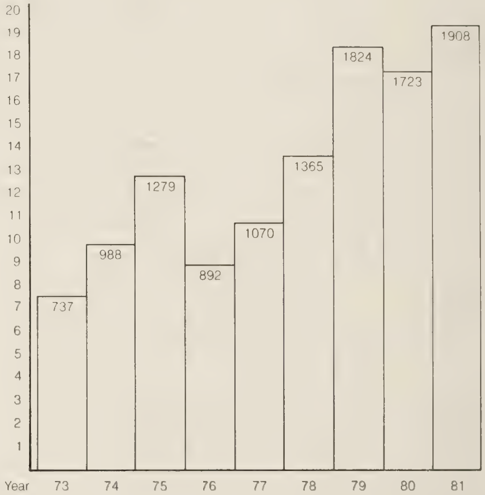
These incidents of violence appear to be increasing annually and it has cast a deepening shadow over the practice of pharmacy.

I believe there are several reasons for this increase in violence directed against pharmacists. The quantity and quality of street-drugs has apparently dryed up due to increased effective law-enforcement activity. Addicts are faced with undependable supplies of the narcotics they must have. In their minds, the robbery of a pharmacy with a weapon is less hazardous than the drug buy in the dark alley with its own potential for violence and rip-offs. These are desperate individuals. They are prone to irrational behavior and spontaneous violence. The pharmacist knows that when he or she is confronted by such an addict demanding drugs, that casual but fatal violence is a definite possibility even as the robbers demands are being met.

The effect of all of this on the profession of pharmacy has been profound. It is impossible to talk to a pharmacist who has been in practice for only a few years who has not endured the trauma of a robbery. It is the most frightening experience you can imagine. As small businessmen, pharmacists have had to deal with the possibility of a robbery or burglary in the past. But these new crimes involving drugs and their increasing trend, represents a new and more severe threat to our profession.

Incidence of Pharmacy Robberies to Obtain Controlled Substances* 1973-1981

160% Increase



*Source DEA

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The pharmacy profession is proud of the fact that it is so widely accessible to the public. Pharmacy does not have the manpower distribution problem that other health care professionals experience. The pharmacist is on every Main Street in America, providing patient information and quality pharmaceuticals to the public. Yet it is that very accessibility that is threatened. For example, in Baltimore City, it is now impossible to find a 24-hour community pharmacy. Increased pharmacy robberies during the late evening and early morning hours have forced Baltimore area pharmacists to stop this community service. Working with our Association and the Board of Pharmacy, several pharmacists have made arrangements to provide after-hour service to patients with emergency prescriptions; but they will make the special trip to open their pharmacies only if a law-enforcement officer is also present.

There are other effects. Many newly graduated pharmacists are now turning away from the practice of community retail pharmacy because of the increased potential for violence. The pharmacy schools are now approximately half male and half female in enrollment. Many of these students are choosing to enter hospital pharmacy practice, manufacturing or other areas of the profession rather than work in community practice. Yet we now have seen reports where even hospital pharmacies have been robbed by those in search of these drugs. Some community pharmacies that have been repeatedly robbed have great difficulty recruiting pharmacists to work.

Pharmacy is a public and patient oriented health care profession. Today's pharmacist is trained to interact with the public and provide valuable medication information. Unfortunately the trend in pharmacy violence has had the effect of making some pharmacists defensive. A pharmacist must constantly be on guard and watchful for the one patient who approaches with the wild-eyed look and the concealed weapon.

In Towson, Maryland, Kaufmann's Pharmacy posted a sign in its window informing the public and potential robbers that it no longer carried Schedule II prescription drugs after it was robbed twice in one month. Most pharmacists have not chosen to do this because of their desire to serve the public health. But this drastic measure is a symptom of the defensiveness I have observed in Maryland Pharmacists.

Pharmacists have now armed themselves. As I attend continuing education seminars and other pharmacy meetings, I have noted that more and more pharmacists, especially those who have experienced robberies in the past, are armed for self-protection. It is a sad commentary on our society when individuals engaged in a health care occupation in the community are forced to carry the very tools of violence for their own self-protection.

I know that there can be little disagreement about the nature and scope of this problem. I also realized that a complete and total solution for what is only one manifestation of a deeply rooted problem in our society is not within our grasp. There are, however, some measures that can be taken which will act as a deterrent to the violence I have described. I urge the Committee to support the intent of Senate Bills 20, 661, 954, 1025, and 1339. Something must be done to assist the pharmacists in this country who are quite literally, risking their lives due to the unique nature of their trade. I urge that you seriously consider mandatory minimum penalties for those convicted of Pharmacy robberies. Send a message to those addicts who believe that knocking over the neighborhood pharmacy is the easy way to secure drugs. We ask you to take firm and positive action to strengthen the prosecution and penalties for those who would rob pharmacies.

The MPhA was invited to present testimony before a Senate Congressional Committee on the subject of pharmacy burglaries. Presenting testimony in favor of tightening penalties and making pharmacy burglaries a Federal crime are: (left to right) Melvin Rubin, MPhA Treasurer; David Banta, MPhA Executive Director; Sheldon Fantle, Peoples Drug Stores; and Stanley Siegelman, Editor-in-Chief of *American Druggist*.

Thank you again for this opportunity to testify before this Committee. I would be pleased to attempt to answer your questions.

Mr. Chairman and members of the committee, my name is Melvin Rubin. I am the owner of J. and S. Pharmacy, a practicing pharmacist in Arbustus, Maryland. The problems of pharmacy robberies is more than just a growing statistic to those persons who have been at the wrong end of a gun held by a glassy-eyed addict. Twice in the past 12 months or so my pharmacy, which is in a middle class neighborhood has had unsocial calls from persons willing to risk jail for drugs—during daylights hours, in a well lit, fully exposed to walking traffic location.

Nothing in my pharmacy is inviting to an addict—it is small, the windows are completely open to view across the expanse of the building, and stores on either side have continuous traffic. Nothing is inviting except one thing—the drugs that cost me comparatively little but are worth great risk to the robber.

Our last holdup cost us about $600 in merchandise—almost completely it cleaned out our schedule II items plus select III drugs, yet it was worth the armed robbery conviction that might have followed.

Ironically, these two holdups came the same day the police made a bust in illegal narcotic traffic in the area. My problem then, is that the more effort that is used to break up these rings, the more threatening the situation becomes for those of us on the hot spot—with the drugs in stock when the need is there.

This is more than a situation where a merchant needs police protection. Being robbed for money and merchandise other than drugs means being confronted by a person who at least might be rational—might understand that pulling the trigger is going to put him in even more jeopardy. Being confronted by a person whose eyes are so wild looking that they are still clear in my mind is another problem—certainly reasoning will not help and the only thing you can do is hope he leaves, before the urge comes to squeeze. You even have to hope the police will not happen on the scene until he leaves or you can expect to go with him. If you are left able to move at all.

Certainly the situation calls for a better system of protection for pharmacies and absolutely for stiffer penalties for those caught. In the case of irrational people, the only deterrent is keeping them where they are not in contact with the population.

The Testimony was given before Maryland Senator Mathias's Subcommittee on Criminal Justice on June 17, 1982.

The Etymology of Medical Terminology

by Stephen J. Provenza, Phar.D.

Shakespeare is regarded as the greatest English poet and dramatist. His education is often regarded as having "little Latin and less Greek." He succeeded in his outstanding career because he was determined to overcome this short-coming.

Because Shakespeare's son-in-law was a physician his iridescent intellect could not fail to appraise the medical profession. A study of his plays gives a surprising insight into his views—often clairvoyant—on the healing art as a science.

The pharmaceutical, medical and dental student is often unable to use his or her knowledge of the classical languages in determining the etymology and meaning of the ordinary basic medical scientific terms used in anatomy, physiology and pathology. This is true because the classics that they have studied are more from the literary rather than from the philological point of view. We find that the Greek terms were Latinized and were subsequently modified in France; we ourselves have been, and still are, anglicizing them. Any pretense of obeying the rules of Greek or Latin grammar has been abandoned.

By studying the list of words that have been given in this study, the anatomical terms in many instances are derived from the Latin whereas the pathological terms are from the Greek. It can be proven by consulting a medical dictionary that 75% of the present English medical terms can be traced to the Greek of Hippocrates who was born about 480 B.C.

Many recent medical terms in the fields of bacteriology, pharmacology and psychiatry were created by using the everyday Latin vocabulary. Many of these words vary in their spelling.

Approximately 25% of the words in the medical dictionary are formed with the aid of a prefix or a suffix—indicating their importance.

The following are many basic medical words:

English	Latin	Example	Greek	Example
All	Omnis	Omniscience	Pan	Panorama
Ankle	Talus	Talipes	Astragalos	Astractalar
Bed	Lectus	Lectularis	Kline	Clinic
Bird	Avis	Aviator	Ornis	Ornithology
Black	Niger	Nigronfier	Melas	Melanoma
Bladder	Vesica	Vesicle	Cystis	Cystitis
Blood	Sanguis	Sanguinary	Haima	Hemorrhage
Break	Ruptis	Rupture	Thrypsis	Lithotrypsy
Breath	Spiro	Aspire	Pnoe	Apnea (Not Breathing)
Buttocks	Natis	Nates	Gloutos	Gluteus
Cheek	Bucca	Bucca Sulcus	Melo	Meloplasty
Chest	Pectus	Pectoral	Stethos	Stethoscope
Coal	Carbo	Carbon	Anthrax	Anthracosis
Cross	Crux	Crucifix	Gammation	Gamma Rays
Digest	Digero	Digest	Pepsis	Syspepsia
Ditch	Fossa	Fossula	Taphros	Taphronose
Drug	Medicatus	Medicated	Pharmacon	Pharmacist
Dry	Siccus	Desiccator	Dipsa	Dipsomaniac
Dust	Pulvis	Pulverize	Konis	Coniosis
Ear	Auris	Auritis	Otos	Otitis
Egg	Ovum	Ovate	Oon	Oocyst
Eye	Oculus	Oculist	Ophthalmos	Ophthalmology
Eye Lid	Palpebra	Palpetral	Blepharon	Blepharitis
Fast	Rapidus	Rapid	Tachys	Tachometer
Fat	Adeps	Adipose	Lipos	Lipase
Finger	Digitis	Digit	Daktylos	Dactyl

English	Latin	Example	Greek	Example
First	Primus	Prime	Proto	Prototype
Fish	Piscis	Piscator	Ichthys	Ichthyology
Foot	Pedis	Pedal	Podos	Podiatry
Fork	Furca	Bifurcation	Bisulcus	Cloven
Glass	Vitrium	Vitreous	Hyalos	Hyaline
Gold	Aurum	Auriger	Chrysos	Chrysinos
Grape	Uva	Uvala	Staphle	Staphylococcus
Gray	Cinis	Incinerator	Polios	Poliomyelitis
Green	Viridis	Verdant	Chloros	Chlorophyll
Gut	Intestina	Entera	Enteron	Enterocele
Hair	Capillus	Capillary	Trichos	Perithrix
Hand	Manus	Manual	Cheir	Chiurgic
Head	Caput	Capital	Kephale	Cephalic
Heat	Caldus	Calorific	Therme	Thermometer
Hip	Coxa	Coxalgia	Ischion	Sciatica
Hole	Foramen	Opening	Hiatus	Vacant Space
Horn	Cornu	Corneus	Keratin	Keratitis
Horse	Equus	Equine	Hippos	Hippuric
Hundred	Centum	Centimeter	Hekaton	Hectogram
Ice	Glacies	Glacial	Kryos	Cryotherapy
Jaw	Mandible	Maxillary	Gnathos	Gnathic
Knee	Genu	Genuflect	Gonatos	Gonagra
Kidney	Renis	Suprarenal	Nephros	Nephrosis
Know	Doctus	Doctor	Sophos	Philosopher
Lip	Labium	Labial	Cheilos	Chiloma
Liver	Jecoris	Jecoral	Hepar	Hepatitis
Lung	Pulmo	Pulmonary	Pneumon	Pneumonia
Marrow	Medulla	Medullaris	Myelos	Myelitis
Milk	Lac	Lactation	Galaktos	Galactic
Moon	Luna	Lunar	Mene	Meniskos
Mouth	Oris	Osculate	Stoma	Stomatitis
Muscle	Musculis	Muscular	Myos	Myology
Nail	Unguis	Finger nail	Onycho	Finger & toe nails
Nipple	Papilla	Papillate	Thele	Thelitis
Nose	Nasus	Nasal	Rhinos	Rhinitis
Oil	Cleum	Cleaceue	Lipos	Lipase
Pestle	Pistillum	Pistillate	Tripter	Trypsin
Purple	Purpura	Porphyritic	Porphyria	Porphyrins
Pus	Puris	Purulent	Pyon	Pyorrhea
Rabbit	Cuniculus	Burrow	Lagos	Lagophthalmos
Red	Ruber	Rouge	Erythros	Erythromycin
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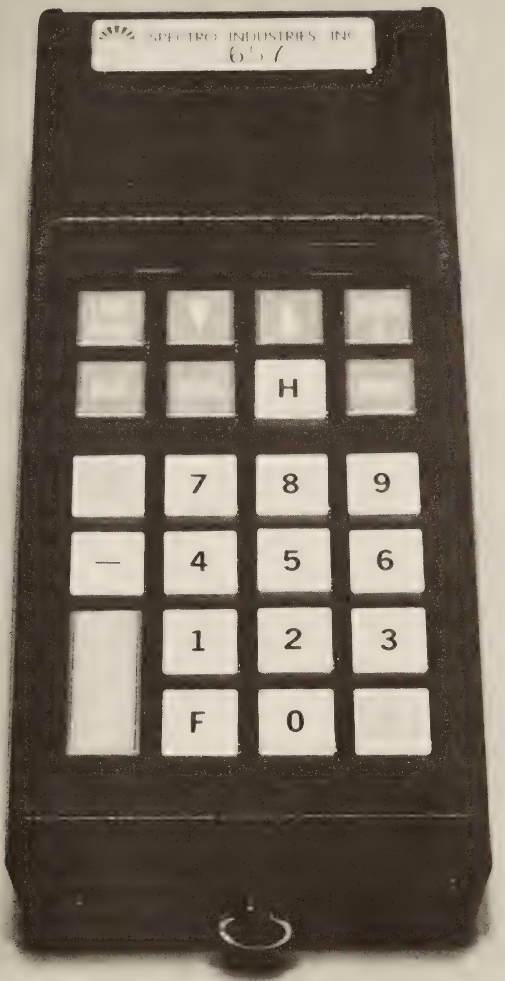

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ASSOCIATION

Executive Director Report

I am personally honored to deliver the report of the Executive Director at this, our one-hundredth Annual Convention. It has been an eventful year since my last report. Now that we are in the midst of our Centennial Celebration I often have paused during the accomplishments of this Association to reflect back on those who have met before us. Just as the pharmacists in 1882 saw that there was a need for a strong association of colleagues to face the challenges of that day, so there is now a greater and continuing need for a strong Maryland Pharmaceutical Association. Beginning with about 25 members, this State Association rapidly grew and assumed a respected position within the health care community. We have a long tradition of innovation and leadership. I have reflected upon our Centennial theme. "Remembering where we have been—Deciding where we are going." During the rush of the daily administrative management of this Association, it has often been far too easy for me to lose my sense of perspective. I wonder if the pharmacists who gathered so long ago could envision where it would all lead and how far we would progress. They saw many of their own desires and plans for the Association come to reality in those early days. Through their sacrifice and foresight, we are here today praising their leadership. I hope that we too have that sense of purpose and resolve to continue to build a stronger Association. Certainly the challenges facing us today grow more formidable each year. I am confident that, as we remember our past, we will make the correct decisions about our future.

Many of the accomplishments of the Association during this past year are reviewed in the various committee reports that are presented to this House. I would like to touch on a few highlights and personal observations.

President Cogan brought strong leadership to his office and a specific goal of assisting local Associations as much as possible. Beginning with a leadership conference at last year's Convention, he has visited virtually every active local association in the State and personally offered the assistance of the M.Ph.A. We have witnessed the formation of the Frederick County Pharmacists Association. Working through the Continuing Education Coordinating Council, new programs were established for local association use. He was successful.

Another longtime goal of this Association was to break 1000 members in time for our Centennial year. As you can see from the membership committee report, we not only broke this mark, we shattered it.

After this House of Delegates adopted the official change in professional designation, at last year's convention the Association has worked throughout the year to accomplish a gradual phase-in. The P.D. designation has now been adopted by many Maryland Pharmacists.

Another highlight of this past year came when the Association succeeded in accomplishing the intent of a resolution which was passed by this House of Delegates several years ago—to repeal the mandatory/Price Poster. I believe this is an excellent example of the "resolution process" at work. The leadership of the Association continues to devote resources to bring to reality the policy direction that you as delegates and members provide.

Earlier this year, the Association was informed that it might lose the Kelly Memorial Building due to expansion of University Hospital. However, due to budgetary cutback, the new extension is not as large as originally projected and the Kelly building will remain where it is. With that knowledge we began to upgrade the building; including a complete repainting of the exterior. While reorganizing the interior, we created additional office space which has been rented to an Episcopal campus minister as another source of Association revenue. In conjunction with the Spring Regional meeting—a new Building identification sign was erected on the front lawn.

The Association changed printers for the Maryland Pharmacist to make it less expensive to produce while maintaining a high level of quality. Charles Spigelmire was honored for his 25 years of producing the radio show, "Your Best Neighbor" the longest continuously produced public service radio show in the state. Charlie was replaced by Phil Weiner who continues the show for the Association in this fine tradition.

I wish to commend the work of the Centennial Celebration Committee and its Chairman William Skinner. Bill did a terrific job of planning over the past three years. The Association has provided its members and friends a commemorative apothecary jar, attractive pins, and historical pharmacy prints. The Association has sold to the public the USP books "About Your Medicines" and "About Your High Blood Pressure Medicines" to inform others of our Centennial. Among other items the Association has successfully promoted, the special mounting plaques have been particularly popular with the members.

In other areas, I thought it was especially significant that the Association supported the Division of Drug Control with a contribution to publish an emergency newsletter vital information. A contribution was also made to the Poison Control Center in support of National Poison Prevention Week Activities.

Legislation was another bright spot for the Association. Working with the Code Commission, we saw the successful completion of the recodification of the Pharmacy Practices Act. I have already mentioned the repeal of the price poster. We were also successful in lobbying for a 30-Cent increase in the Medicaid Dispensing fee—taking it to $3.25. Working with the results of the new cost survey, we hope to provide justification for more increases in the future.

These were a few of the many issues which we grappled with over this past year. Much remains for us to do.

I am very excited about the purchase by the Association of a word processor. I believe it will place us into a new era in terms of efficiency and membership services. New and continuing challenges face us. The issues of prescriptive authority for allied health care groups and our role in this process remains to be clarified. The Association will decide how to deal with the issue of chemically impaired pharmacists. We must continue to improve the relationship that exists between all state pharmacy organizations. We must continue to fight for the economic survival of the independent practitioner. We must continue the fight to expand the scope of care that pharmacists can provide to the public and receive remuneration for it. WE must work to foster a better public understanding of our unique knowledge base and contribution to the health care delivery system. And we must work for unity of purpose and a consensus of professional goals among *all* pharmacists; regardless of practice specialty, academic degree or previous experiences.

I personally believe in the group process. Our Association is the viable instrument for determining the collective destiny of this profession. Those who do not join this process have, by defacto, made a critical decision on issues we will decide in the near future.

Perhaps events moved more slowly 100 years ago. Still pharmacists perceived the need to band together for the common good. Our "super-sonic" age calls upon us to continually adapt and seek better solutions to our mutual problems. While I continue to be fascinated with the rich heritage of Maryland Pharmacy, I am equally excited about the prospects for future challenge. Successfully meeting those challenges will permit us to soar into the future so that, one hundred years from now, those who will come after us will perhaps say our labors for pharmacy were successful in ways we cannot now even imagine.

Thank you.

David A. Banta
Executive Director

The Student American Pharmaceutical Association Report

The Student American Pharmaceutical Association, University of Maryland, Maryland Pharmaceutical Association, (SAPhA) has had a very successful year. This past year SAPhA directed its activities toward increasing student participation, faculty involvement and stronger student, faculty and pharmacist unity. Along with these goals, we were able to increase membership more than 25%, with this years membership more taking a more active part in SAPhA's activities.

Our chapter participated in many fund raising activities this past year. Some of the activities included bake sales, raffles, T-shirts and book sales. All of the money that was raised helped support students who attended the fall regional and 1982 Annual SAPhA meetings.

This year our chapter also tried to identify Pharmacy students with the other professions by sponsoring an interdisciplinary program in which all professional students were invited to attend. This program entitled, "Sex Education in Today's Society, The Effect on the Health Professional", involved mime that portrayed many situation problems teenagers face today and how the health professionals may help in these various incidences. This year we also presented 2 biannual coffeehouses in which the entire UMAB campus, faculty and pharmacists were invited to attend and participate.

Out-going President Philip Cogan (right), receives a Special Award from SAPhA President Cheryl Betz (left) on the occasion of the Association's Centennial Celebration. The Plaque is on display in the Kelly Building with other Commemorative awards given to the Association during the past year.

Our chapter was also involved in many programs which benefited the community. We participated in taking blood pressures as well as helped Rutgers University in cooperation with the New Jersey Pharmaceutical Association establish an Elder Ed program in their state similar to the one in Maryland.

This year we also undertook the project on redoing the museum in the Kelly Memorial Building. Several students worked a few hard weekends to refurbish the museum for visitors.

During the meetings held this year our SAPhA chapter was very fortunate to have two of its members Taher Sheybani and Brian Sanderoff run for national office and Dudley Demarest who was the Speaker of the House at the national meeting held in Las Vegas.

Probably the most rewarding project for myself and the chapter has been working on this year's regional meeting which will take place here this fall on November 4–7 at the Baltimore Hilton. The meeting entitled "Communicate Professionalism" is an opportunity for students, faculty and practicing pharmacists to all participate. Everyone is invited to attend and participate at the meetings and banquets at the low fee of $20.00. Further information will be available later on.

In conclusion, on behalf of our chapter of SAPhA, I would like to take this opportunity to congratulate the MPhA on your Centennial year, as well as thank you for your continued support. We are thankful for the relationship our student chapter has with the state association because it has enabled us to interact directly with the association and given us an opportunity to get involved in many leadership roles.

I would also like to take this opportunity to thank several people who have directly supported SAPhA this year and in the past, and without them our chapter would not have progressed as far as it has. They are: MPhA; MPhA Staff—Dave, Bev & Mary Anne, School of Pharmacy Alumni Association; School of Pharmacy Faculty; Donald Fedder—Our Faculty Advisor; Dean William Kinnard; Dean Leavitt—Our Faculty Treasurer; and most importantly the students at the school of pharmacy who without you SAPhA would not have existed at all.

Finally, SAPhA hopes the next 100 years of the Maryland Pharmaceutical Association will be as eventful to the Maryland pharmacists and students as the past.

Cheryl Betz

Convention Reports

Report of the Speaker of the House of Delegates

Traditionally, at the Annual Convention, the Speaker of the House of Delegates is asked to report on the general membership meetings held during the year. It pleases me to observe that, as this Association enters its second century, we took some innovative approaches to both our Fall and Spring meetings.

The Fall Regional, held at the Quality Inn in Catonsville, was devoted to a continuing education program jointly sponsored by this Association and the Continuing Education Coordinating Council, a first for such a cooperative effort. The Smith, Kline and French Company presented an individually paced video-tape program on Personal and Personnel Management. The House of Delegates meeting was suspended as there was no business to be transacted.

The 1982 Spring Regional meeting was held in the Kelly Memorial Building and the Association formally kicked off its Centennial Celebration with the dedication of a sign placed on the front lawn to identify the building and commemorate our 100th anniversary. Centennial Committee Chairman William Skinner presented Association president Phil Cogan with a plaque honoring Maryland Pharmacists William Proctor and David Stewart.

The rest of the meeting was devoted to an issues forum. The intention of this program was to discuss future directions for the Association. Representatives from various pharmacy organizations in Maryland were invited to express what they saw as major issues for both MPhA and pharmacy in Maryland. Dean William Kinnard, (School of Pharmacy), Bernard Lachman, (president, Maryland Board of Pharmacy), Bill Grove (President Maryland Society of Hospital Pharmacist), Ron Tekak (Past President, Maryland Society of Hospital Pharmacist), Marty Mintz (President, Md. Chapter, American Society of Consulting Pharmacists) and Phil Cogan (President, MPhA) made brief opening statements on how they view the major issues in pharmacy. The rest of the meeting was opened for discussion from the floor. Matters dealing with economic issues and curriculum changes were emphasized, but primarily we focused on the quality of care to the public as our major concern. We all agreed that we need to continue to work for closer cooperation among all the pharmacy organizations in Maryland as one way of achieving our goals. We were delighted to see, in addition to our members, guests from other local and neighboring national associations. The program was well received. Following the program, a wine and cheese reception was held on the lower level of the Kelly Building, and I would note this too, was well received!

My report would not be complete without expressing my gratitude to David Banta, Executive Director of M.Ph.A. for his support and enthusiasm as well as his guidance in planning the programs for the Association.

Madaline Feinberg

Continuing Education Coordinating Council Report

The Continuing Education Coordinating Council has just completed another successful season of providing continuing education opportunities to Maryland Pharmacists. I believe that we can all be proud of our Association's participation in this unique, tripartite, cooperative effort that has proved to be beneficial to all concerned. I wish to offer a personal expression of appreciation to all of those who serve on the Council and who have freely given of their time over the past year to plan and execute these programs.

Over this past season, the Council provided programs on the following subjects, Personal/Personnel Management (in conjunction with the M.Ph.A.'s Fall Regional Meeting), Pulmonary Diseases, Pediatrics and Drug Therapy during pregnancy, and Oncology. In addition to these, the Council decided to advance program resources available outside the Metropolitan area by initiating the "New Drug Road Show". By identifying a number of qualified volunteer speakers, we were able to offer this popular program to the seven local Associations in Maryland. Virtually all of them took advantage of this opportunity and the Council plans to make this road show a permanent offering.

For the coming season, the Council has arranged for additional programs to meet the educational needs of Maryland Pharmacist. We have selected these based on responses to our program evaluations. The Council has attempted to become sensitive to the comments of Pharmacists so we might improve our program offerings. Subjects to be offered include: Cardiovascular Drugs, Diabetes Mellitus, Alcoholism, Rheumatoid Arthritis, and Stress. The Council will be issuing detailed announcements about these programs for interested Maryland Pharmacists.

The Council is also interested in involving individuals who wish to assist in planning continuing education opportunities. I think you can tell that the Council is a very active and productive organization. It is successful due to the individuals who have taken the time and effort to participate in this worthwhile activity. Please contact me if you have any suggestion for the Council or if you wish to become an active contributor to the Council's work.

David Banta
Chairman

Past Speaker of the House Madeline Feinberg (left) receives the Out-Going Speaker Award from Charles Spiglemire (right), the Centennial Convention Banquet Grand Marshall.

William Skinner, General Counsel for the U.S. PharmPAC delivers his report to the business session of the House of Delegates.

The United States Pharmacists Political Action Committee Report

The officers and board members of U.S. Pharm PAC join with me in saluting the Maryland Pharmaceutical Association on its 100th anniversary meeting. Compared to the age U.S. Pharm PAC started in 1978, the Maryland Association is a great grandfather.

We should add that the Maryland Association is a really *great* grandfather for more reasons than age. Among the more professionally motivated pharmacists of the nation, several Marylanders have taken leading roles in helping to establish and carry on political activities on behalf of the nation's pharmacists.

Richard D. Parker, a past president of this Association and the organizing treasurer of U.S. Pharm PAC stepped down during the year as treasurer and in his place the board elected Allen J. Brands. Allen Brands, a University of Southern California pharmacy graduate, retired in 1981 as the Chief Pharmacy of the Public Health Service at the rank of Vice Admiral—the first pharmacist to ever gain the flag rank as a pharmacist.

Another bright star in Maryland is U.S. Pharm PAC Board Member Stan Yaffe, a stalwart member and worker of your association. Without the dedication, hard work and constant support of men like these, there can be no political action.

U.S. Pharm PAC is alive, but not well around the Country. The profession needs the help that a PAC can give, but we do not seem to be getting it going.

My own thoughts about how to remedy this situation have been reinforced time and again when I observe other PACs become organized and take off successfully. The basis of the success of other PACs is their ability to sustain a prolonged and repeated mail solicitation. This costs money and our PAC has never had the requisite amount of money. In short, we can't get started big until we have a big amount to invest in fund raising. Naturally it would help if all parts of our profession were pulling together in these matters instead of pulling in different directions.

Pharmacy's political problems are a mirror image of its professional organizations goals and aspirations—these are simply too many directions in a small profession.

Despite these obvious problems, we do have an impact and I believe we will gain support from more and more pharmacists each year. Please do your part to keep Maryland ahead.

William J. Skinner
General Counsel

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P.D.

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PATCH NOW AVAILABLE

The new emblem for pharmacists utilizing the "P.D." designation has arrived. Designed to be sewn on dispensing jackets, these new insignia are embroidered in dark blue with a white background, and cost $1.50 each.

To order, send check or money order for emblems @ $1.50 each to:

Maryland Pharmaceutical Assn.
650 W. Lombard St.
Baltimore, Md. 21201

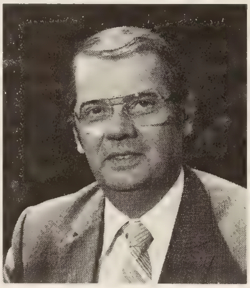
Our best friends are our severest critics and our greatest assets.

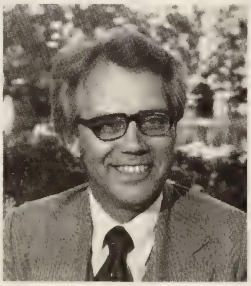
Meet our 1982 Pharmacy Consultant Panel.

H. Joseph Schutte, R.Ph
Community Pharmacist
Louisville, Kentucky

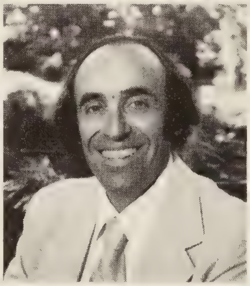
Louis M. Sesti, R.Ph
Executive Director
Michigan Pharmacists Association
Lansing, Michigan

Marilyn Slotfeldt, Pharm.D.
Clinical Services
Good Samaritan Hospital
Portland, Oregon


Donald Hoscheit, R.Ph
Vice President, Pharmacy
Osco Drug, Inc
Oak Brook, Illinois

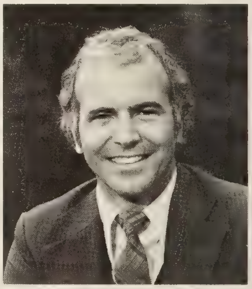

Martin Lambert, Ph.D., R.Ph
Community Pharmacist
Knoxville, Tennessee

Stephen D. Roath, R.Ph
Vice President, Director of
Professional Affairs,
Longs Drug Stores, Inc
Walnut Creek, California


Harold H. Wolf, Ph.D., R.Ph
Dean, College of Pharmacy
University of Utah
Salt Lake City, Utah

Paul Burkhart, R.Ph
Director of Pharmacy
University of Maryland Hospital
Baltimore, Maryland

Harland W. Henry, R.Ph
Director of Pharmacy
Memorial Hospital System
Houston, Texas


Lawrence A. Diaz, R.Ph
Community Pharmacist
Gainesville, Florida

No diplomatic double talk.

We need the advice of pharmacists in order to do a better job for pharmacists. The bad news and the good

That's what the ten members of our 1982 Pharmacy Consultant Panel provide.

Their views on professional and other pertinent matters are invaluable.

Their advice and counsel helps us serve you better in the expanding role of pharmacy.

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LETTERS

Dear Dave,

Will you express to the Maryland Pharmaceutical Association our sincere thanks for the very beautiful arrangement of flowers sent to us at the time of Vic's death? That is such a very lonely time and knowing that Vic's friends were thinking of us helped so very much.

I was most grateful for your letter concerning the action taken at the Convention. Vic's profession was as central a part of his life as was his family and his faith. His every action revolved around those three precious things. It is most gratifying to know that he was so loved by the men he respected so much. Please express my thanks to them and my hope for a bright future for Pharmacy in Maryland.

Sincerely
Frances L. Morgenroth

Dear Mr. Banta:

The Following is a continuing education conference being conducted by the Medical College of Virginia, School of Pharmacy:

"The Pharmacist and Pain Management: New Concepts in Pharmacotherapy of Pain"
Sunday, October 31, 1982
8:15 a.m.–5 p.m.
Fort Magruder Inn
Williamsburg, Virginia

CONTACT: Dr. Werner Lowenthal, Director
Continuing Education
School of Pharmacy
(804) 786-0334

Sincerely,
Werner Lowenthal, Ph.D.
Director, Continuing Education

Dear Mr. Banta:

At this late date, may the Executive officers, members and staff of the Colorado Pharmacal Association extend congratulations and best wishes in this your centennial year.

Your accomplishments and contributions to this profession have been many and varied and to have attained this milestone must provide great satisfaction to you and your members.

To have reached your goal of 1,000 members by your centennial year is a great accomplishment and, while the first 100 years are the hardest, they can also be the proudest.

Arthur C. Hassan, Jr.
Executive Director

Editors Note: This letter was read to the House of Delegates as they considered a Resolution regarding the USP's Dispensing Information. The Resolution was tabled. See the August Issue for the Resolution.

Dear Dave:

I appreciate the high regard shown for USP DI by the Association's proposed resolution. Doubtless the Association is aware that the original intent was to publish the Dispensing Information as a part of USP itself. Protestations by national pharmacy organizations have persuaded the USPC Board of Trustees to publish DI separately thus far.

Be that as it may, the proposed resolution to eliminate the requirement that pharmacies have on hand the current USP and its supplements needs thorough and thoughtful study before being presented to the Association for a final recommendation. Timely as the proposal may seem, giving up the presence of the Pharmacopeia in pharmacies represents a loss of Power for Pharmacy.

Just how much loss and the possible ramifications need study. The federal Food, Drug and Cosmetic Act recognizes the USP standards of strength, quality, and purity, and USP requirements for packaging and labeling; and the federal Food and Drug Administration is authorized to enforce those determinations. Thus compliance by the *pharamacist* would still be required and presumably the conscientious or worried pharmacist would buy the book even though the *pharmacy* was no longer required to have it for its pharmacists.

The book itself, not the organization, is recognized in the Law. It must be appreciated, however, that the organization that writes the book is, although nongovernmental and biprofessional, in fact controlled by Pharmacy (by sending a majority of the delegates and by the power of the pocketbook). Thus any loss of prestige, authority, or ubiquitousness by the USP is a loss to Pharmacy. Although the ramifications might vary somewhat from state to state, it is highly appropriate that Maryland be the first to study the situation in relation to modern practices and requirements. It is, after all, the state where USPC is headquartered and the Chairman of the Board and the Executive Director both are members of the Association.

I suggest that the proposed resolution be referred to a MPhA committee that would look into the matter thoroughly and come up with a recommendation next year that would provide information useful to both MPhA and USP. I or other members of the USP staff stand ready to serve on the Committee, if requested, or to serve as resource persons to the Committee.

I regret that I have meetings here this week that I cannot get out of and will cause me to miss the MPhA this year. I would appreciate your providing this letter to the Resolutions Committee and extra copies are enclosed for your convenience.

Sincerely,
William M. Heller
Executive Director

Your Peer Review Committee in Action

This letter and response was read to the Association's House of Delegates as an example of the kind of activity the Peer Review Committee has generated. It was recommended that these letters be shared with the membership with all identities obscured so that pharmacists will have a better understanding of both sides of a typical consumer complaint received by the Committee.

Gentlemen:

I am writing to complain about a druggist, __________, owner of __________ Pharmacy located at __________ Avenue.

My son was released from Church Home Hospital on May 13 at 9:30 A.M. after back surgery for a slipped disc. He was bedridden, unable to drive and in a great deal of pain. A fellow roommate at his residence took a prescription written by Dr. __________ on Church Home & Hospital prescription pads with the i.d. number to a pharmacy in __________. when the roommate returned to the drug store he was informed they didn't have the drug needed. Unfortunately, half a day had passed by the time this information was learned. The roommate proceeded to __________ Pharmacy where upon Mr. __________ advised that before he could fill the prescription he would have to speak to the doctor.

The roommate informed my son of this upon his return home. My son called the druggist explaining how much pain he was in and suggested that Mr. __________ contact the hospital where he could get a confirmation of the authenticity of the prescription, since according to Mr. __________, he had been unable to reach Dr. __________. At this suggestion, Mr. __________ hung up on my son.

This is where I became involved in this fiasco. My son's roommate called me on my job very upset about Mr. __________'s attitude. I personally called Mr. __________ and was shocked to learn that my son and his roommate were not exaggerating.

Mr. __________ would not answer my questions as to why he wouldn't put forth some effort to contact Dr. __________. Talking to Mr. __________ was like talking to a wall. In desperation I asked the druggist for his name and at first he refused to tell me. I commented "You are in business and you don't want to tell me your name?" Finally, with reluctance, Mr. __________ identified himself.

I apologize for the length of this letter, but it is necessary to give you the dialogue exchange in order that you may determine how uncooperative and rude Mr. __________ was to me and my son.

I finally got Mr. __________ to identify himself on the phone and his next comment was "I hope you are satisfied." He also kept yelling "Have your son drive down here and get the prescription and take it elsewhere," even though I had explained three times that my son was unable to drive anywhere to pick up anything. Mr. __________ then said that he did not know who my son was and couldn't be sure that I was his mother on the phone. It was finally obvious to me that we were having a one-way conversation. Would you believe Mr. __________ hung up on me?

All of the above created an eleventh hour situation for me since I cannot leave my job until 5:30 P.M. The drug store closed at 6:00 P.M. and I had to retrieve the unfilled prescription before the drug store closed in hopes that I could get it filled elsewhere. I won't elaborate on my mad dash during rush hour traffic from my job on Patapsco Avenue in Baltimore City to the drug store in __________.

When I reached the drug store I was left standing at the counter for at least three minutes before Mr. __________ even looked up to acknowledge my presence. It was at this point, for the first time, that the druggist advised it was his policy not to fill a prescription unless he spoke to the doctor personally. Needless to say, I find that hard to believe.

My question to you is this. Doesn't a pharmacist have a moral obligation, responsibility or ethical sense of duty to provide for a patient's needs after he leaves a hospital? Are we, the general public, to be at the mercy of men like this who decide to play "God?"

My son experienced a great deal of pain his first night home from the hospital thanks to Mr. __________'s unreasonable, unsympathetic attitude, to say nothing of his neglect and lack of common sense and compassion.

Needless to say, my son, nor I will ever do business with the __________ Pharmacy again. Unfortunately, Mr. __________ will continue to inflict his own brand of torture on the unsuspecting public.

I would certainly appreciate any type of reprimand you could give to Mr. __________. A friend of mine who owns a business in the __________ area advised me not to waste my time writing letters complaining about Mr. __________ since, as he put it, "He owns half of __________." Is this, then, to be another case of the "little guy" getting stepped on by those in power?

Very truly yours,

CC: Maryland Board of Pharmacy Licensing
Matt Seiden—The Sun

The Committee's Response

Dear __________:

We were sorry to hear about the unfortunate difficulty your son had in trying to get a prescription filled.

We in the pharmacy have always been concerned that such an incident would occur, and I would like to explain why it did happen.

Pharmacists have been plagued with armed holdups, break-ins and forged prescriptions by individuals searching for narcotics. In addition, they have been prosecuted for filling narcotic prescriptions that have not been properly authenticated by the prescribing doctor.

According to Dr. __________, your son had a prescription for Tylox, a narcotic, written on a hospital blank, which is a notorious source for forged narcotic prescription. The prescription was presented to the pharmacist by a youth who had arrived on a motorcycle, who admitted that the prescription was not for him.

The pharmacist had told your son on the phone that he had the drug, but would not fill the prescription until its authenticity was confirmed. Dr. __________ called the hospital and was told that Dr. __________ was not there. He then called another number which the hospital personnel gave him, but was still unable to reach Dr. __________.

This explains the dilemma that the pharmacist was in. We can not condone any rudeness on his part, but it was a legitimate judgement call.

The pharmacist's livelihood depends on filling prescription; he loses time and money when he does not fill the prescription. Like most pharmacists Dr. __________ was doing what he thought was in the best interest of the public.

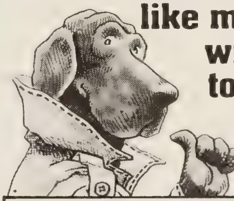
To avoid any future problems, we would suggest that you patronize one pharmacy; one that maintains a family record file. With such a record, your pharmacist would know each individual and be aware of his complete drug history.

Thank you for your informative letter, it makes us more aware of the viewpoint of an innocent victim of our complex modern society.

Sincerely,
Irvin Kamentz, P.D.
Chairman, Peer Review Committee
Maryland Pharmaceutical Association

Irvin Kamenetz, Chairman of the Peer Review Committee reviews the work of the Committee over the past year and shared with the House of Delegates a typical letter of complaint and the Committee's response.

What business does a handsome dog like me have with a top cat like you?



My name's McGruff,™ and it's my business to help prevent crime. I think it should be your business, too—to teach your employees how to protect themselves. Just send for my business kit—it'll help you develop a program that teaches your employees how to make their homes burglar-proof, make their neighborhoods safer, even how not to get mugged.

So take the time, and...

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Write to McGruff, Crime Prevention Coalition, 20 Banta Place, Hackensack, NJ 07601 for lots of information on Crime Prevention.

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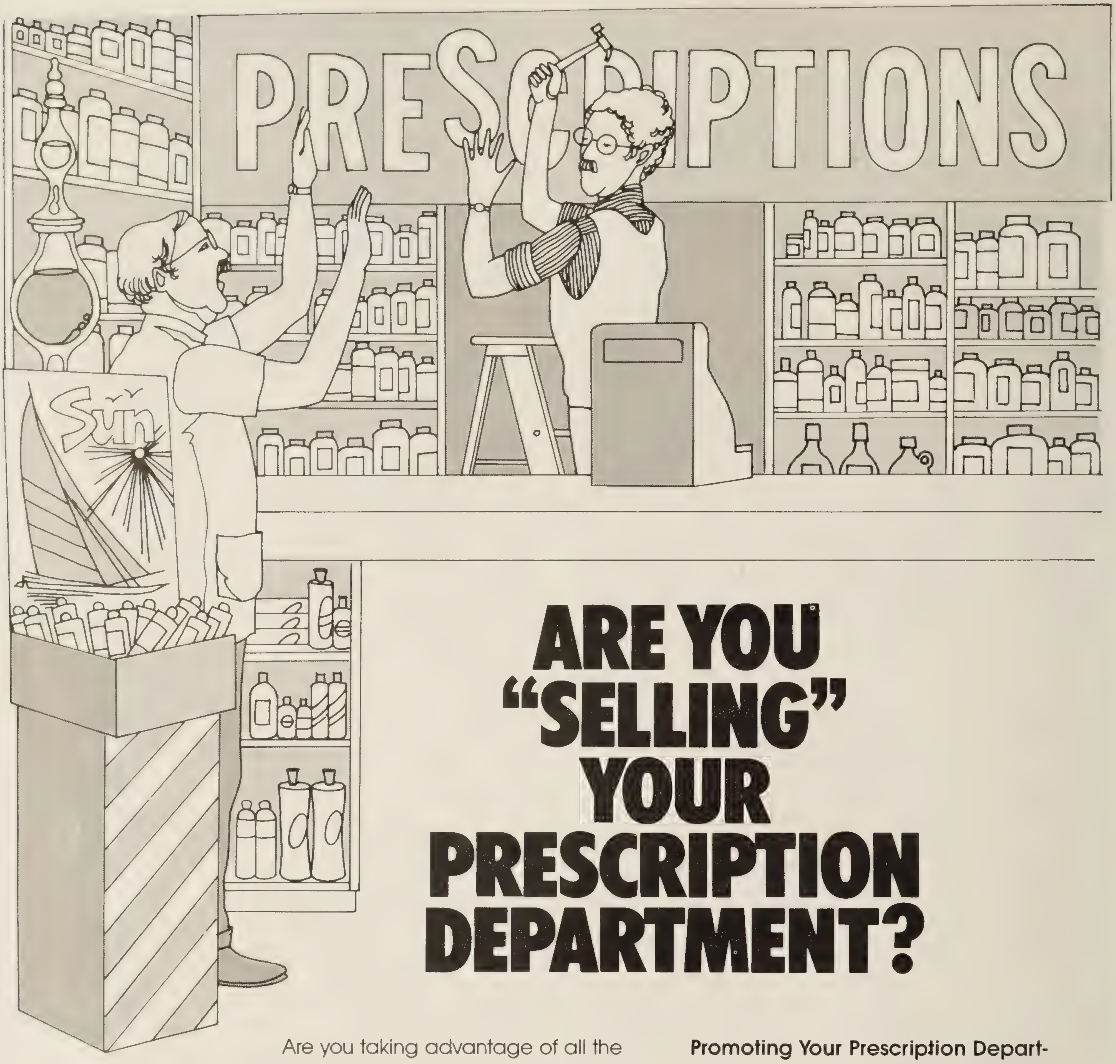

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Our new management program is called **Promoting Your Prescription Department**—and it's designed as a seminar for interested groups of community pharmacists.

You can learn more about advertising, promotional budgets, personal selling, publicity, pharmacy layout, and evaluation of your promotion efforts.

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ASCP's Statement to the APhA Task Force on Pharmacy Education

by Jerome L. Fine, M.S., P.D., FASCP, ASCP President

Jerry Fine is President of the American Society of Consultant Pharmacists and a member of the Maryland Pharmaceutical Association. He delivered these remarks to the Task Force on Education at the APhA Convention in Las Vegas.

The practice of pharmacy in the United States continues to change at a rapid pace. Some practitioners, academicians, and other pharmacy leaders maintain that this change is evolutionary while others claim that it is almost revolutionary. For varying reasons, however, most do agree with the assertion that pharmacy education has not responded to these changes in the most appropriate fashion.

Certain changes in pharmacy practice have been precipitated by the profession's desire and efforts to expand its role and recognition in the delivery of health care services. Other changes, however, have been forced on the profession through external factors. Both internal and external pressures that have and will continue to alter the manner and scope of pharmacy practice must be well recognized and understood by those responsible for developing and executing the pharmacy education process. This is critical in order to produce graduates that can respond to today's dynamic practice and meet the future needs of the profession.

One of the external factors affecting pharmacy today is this country's growing numbers and proportion of elderly individuals. This shift in the age of the population has only begun to receive adequate attention by our colleges of pharmacy.

By the year 2000, demographers predict a 33% increase in the number of individuals 65 years and older. By then we will have more than 32 million elderly that, as a group, suffer from numerous chronic illnesses and take considerable amounts of medications. The drug consumption patterns of the elderly along with their altered physiologic responses to these drugs create a requirement and opportunity for extensive and special pharmacy services.

Pharmacy students are not being appropriately prepared to provide these special services to this population segment. Today and in the future, pharmacy schools must devote concentrated effort to assure that pharmacists fully understand the physiology, the prevalent pathologies and related drug therapy, and the psycho-social aspects of growing old.

Concurrent with this confirmed increase in the elderly population, we will experience a continued expansion in the number of long term care facilities in this country. Nursing homes and other similar care settings will be necessary to provide shelter and a wide variety of health care and other social services to this population group.

Even today, the number of patients cared for in nursing homes (1.4 million) exceeds our country's acute hospital capacity (1.2 million). In the future, the difference in patient counts will grow as the actual number of acute hospitals continues to decline.

Over the last decade, the role of the pharmacist in the long term care setting has broadened dramatically. Once thought of only as "hospital pharmacist" functions, today's long term care pharmacy practitioner routinely provides extensive drug therapy assessment activities, innovative drug distribution systems, unique administrative and clinical consultant services, policy and procedure development, in-service education programs, and cost-effective computer services.

Even though long term care presents pharmacy with the fastest growing opportunity for professional practice, the specialized area of practice has been largely ignored by our colleges of pharmacy. This fact is evidenced by the lack of clinical rotations of pharmacy students through nursing homes, by the lack of required courses that focus on the medical, social, and pharmacotherapeutic problems of the elderly, and further by the lack of development of long term care pharmacy residency programs. Many colleges have also failed to offer good post-graduate continuing education programs specifically directed toward nursing home practice.

Colleges must recognize the critical impact that pharmacists can make in the nursing home setting and begin immediately to develop under-graduate and post-graduate education programs that meet the information needs that currently exist.

As pharmacists have emerged from behind the prescription counter, a significant weakness in their educational background has become apparent. This weakness is the ability to communicate effectively with the public. In order to adequately counsel patients on drug therapy, pharmacists must be thoroughly skilled in all aspects of communication, both talking and listening.

The importance of the skill transcends simply talking to patients and includes various forms of interaction with other health professions. For example, the value of an effective patient drug regimen review is lost when the pharmacist cannot appropriately communicate his or her recommendations for improvements in that therapy to the physician. Further, all the pharmacist's drug education is almost meaningless if he or she cannot act as the expert in providing education programs for other health professionals such as nurses.

Communication skills will become more and more important to the pharmacist as the degree of patient orientation in the professional practice increases. The proportion of time pharmacists will spend handling drug products in relationship to dispensing activities has already and will continue to diminish. This decrease in the mechanical functions of the pharmacist is motivated by any number of factors including the advent of technology such as computers and tablet counters as well as increases in the number of unit of use packaged drug products. Additionally, the simple economic reality that supportive personnel allow the pharmacist to be more productive is a strong factor in freeing the pharmacist for more patient oriented services.

These factors combined with the demands of the public and the desires of the profession, give pharmacists more time and opportunity to be directly involved with the patient and more need to rely on his or her ability to communicate with individuals.

Another almost universally acknowledged inadequacy in today's pharmacy curriculum is the broad area of business and management. Today's pharmacy graduates are entering practice ill-prepared to deal with the sophisticated business environment that exists irrespective of the practice setting. It matters not whether the graduate chooses independent, chain, hospital, industry, or long term care pharmacy, the need for comprehending the basics of accounting, finance, personnel management, and other business skills exists.

Belaboring this point is not necessary, but a couple examples are illustrative. In long term care pharmacy our membership surveys indicate that almost 60% of the Society's members utilize computers. Obviously, a newly hired pharmacist will be totally lost and unproductive if his educational background only included a typical dispensing laboratory and lacked exposure to computerized prescription processing procedures.

Another example relates to personnel management skills. With the increasing utilization of supportive personnel in all practice settings it is likely that even a newly hired pharmacist will have some degree of supervisory responsibility over these individuals. Without at least rudimentary supervisory skills, that newly hired pharmacist could easily find that he or she is soon grouped by upper management with those supportive individuals.

Another current development in pharmacy practice that has received scant attention by our schools of pharmacy is the increasing numbers of pharmacists that are involved in providing consultant services. These services are being provided to a wide variety of health care settings including home health care agencies, community health care centers, prisons and jails, industrial plants, and hospice organizations among others. The non-dispensing services offered range from simple drug therapy in-service programs to in-depth drug therapy assessment and counseling to recommendations on drug handling procedures.

Surveys of ASCP's membership indicate that almost 40% of Society members are providing consultant services to an organization or institution other than a long term care facility or hospital. This further expansion in the role of the pharmacist highlights the fact that pharmacists have expertise that is valuable in and of itself.

Although our colleges could not be expected to prepare recent graduates to function as expert consultants, it is important, however, that pharmacy students be exposed to the fact that this type of career opportunity is available.

Another issue that cries for immediate attention from our colleges is final resolution of the nature and title of the degree awarded as the initial entry level degree for pharmacy. The current two level degree approach has caused considerable confusion, discension, and anger in the profession and among the public. Adoption of a consistent and single pharmacy entry level degree should be assigned priority by the colleges and the profession.

The diversity of professional pharmacy practice today presents a true dilemma for our colleges in preparing graduates to enter and succeed in the profession. The fact, however, that the profession has attained its current high level and scope of practice attests to the colleges' ability to respond to change and to plan for the future.

The American Society of Consultant Pharmacists appreciates this opportunity to offer our comments to the Task Force on Pharmacy Education.

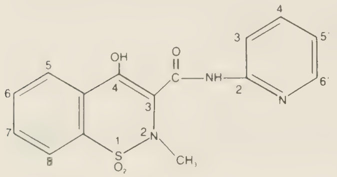
MURPHY'S NEWEST SET OF LAWS

1. There's always one more bug.
2. Build a system that even a fool can use, and only a fool will use it.
3. The reliability of machinery is inversely proportional to the number and significance of any persons watching it.
4. It works better if you plug it in.
5. If it jams—force it. If it breaks, it needed replacing anyway.
6. When all else fails, read the instructions.
7. It won't work.
8. If enough data is collected, anything may be proved by statistical methods.
9. When working toward the solution of a problem, it always helps if you know the answer.
10. All great discoveries are made by mistake.
11. The greater the funding, the longer it takes to make the mistake.
12. The progress of science varies inversely with the number of journals published.
13. There's never time to do it right, but there's always time to do it over.
14. The man who can smile when things go wrong has thought of someone he can blame it on.
15. An expert is a person who avoids the small errors while sweeping on to the grand fallacy.
16. Never sleep with anyone crazier than yourself.
17. Men and nations will act rationally when all other possibilities have been exhausted.

Piroxicam (Feldene®), A Review

by J.Lysle Hendrix, M.S., R.Ph.
Senior Pharmacist
Department of Pharmacy
University of Alabama Hospitals
and Clinics

Piroxicam (Feldene®, Pfizer Laboratories) is the first of the "oxicams"—a new family of nonsteroidal anti-inflammatory agents. Piroxicam is a unique compound, chemically unrelated to the other nonsteroidal, anti-inflammatory drugs.



In clinical evaluation, piroxicam has shown anti-inflammatory, analgesic and antipyretic properties in clinical and animal test systems. Its mechanism of action, like that of other nonsteroidal anti-inflammatory agents, is not completely known. However, a common mechanism may exist in the ability of piroxicam to inhibit the biosynthesis of prostaglandins.

Animal studies have shown piroxicam's anti-inflammatory activity to be twice as potent (weight-for-weight) as that of indomethacin, 7 times as potent as that of naproxen, and 14 times as potent as that of phenylbutazone. Anti-inflammatory activity was also demonstrated against: adjuvant-induced arthritis and granuloma tissue formation in rats; urate crystal-induced synovitis in dogs; and ultraviolet-induced erythema in guinea pigs. (Piroxicam, at doses one-tenth those of aspirin, displayed potent analgesic activity in irritant-induced pain in the mouse to a similar extent as that of aspirin.) Piroxicam was also effective in elevating the pressure threshold in the edematous hind paw of rats. In oral doses of 10 mg/kg, piroxicam was as effective as 56 mg/kg of aspirin in inhibiting pyrexia induced by intramuscular injection of *E. coli*.

In man, piroxicam is well absorbed following oral administration. Drug plasma concentrations are proportional to the doses given for 10 mg and 20 mg doses. They generally peak within five hours after medication, and subsequently decline with a mean half-life of 50 hours.

This results in the maintenance of relatively stable plasma concentrations throughout the day on once-daily doses. A single 20-mg dose generally produces peak piroxicam plasma levels of 1.5 to 2 mcg/ml, while plasma concentrations, after repeated daily ingestion of 20 mg piroxicam, usually stabilize at 3-8 mcg/ml. Most patients approximate steady state plasma levels within 7 to 12 days. Higher levels, which approximate steady state at two to three weeks, have been observed in patients in whom longer plasma half-lives of piroxicam occurred.

Studies show that in man piroxicam is extensively metabolized by the liver. Very little is excreted unchanged, with daily excretion reported at less than 5%. Metabolism occurs by hydroxylation at the 5 position of the pyridyl side chain and conjugation of this product; by cyclodehydration; and by a sequence of reactions involving hydrolysis of the amide linkage, decarboxylation, ring contraction, and N-demethylation. As would be expected from a drug for which renal excretion is only a minor route of elimination, patients with mild to moderate renal impairment have essentially normal pharmacokinetics with piroxicam. As with other prostaglandin synthesis inhibitors, reversible elevations of BUN have been reported.

Clinical studies have confirmed piroxicam's analgesic, antipyretic and anti-inflammatory properties observed in animal studies. Additionally, several studies have been done which compare piroxicam with other drug therapies. When compared with salicylates in maximally tolerated doses, piroxicam 20 mg daily produced comparable improvements in all measured parameters with less troublesome side effects. In patients with osteoarthritis the use of piroxicam 20 mg daily was found to be more effective in relieving pain and in improving mobility than the use of aspirin in daily doses of 2.6 g to 3.9 g.

Several studies have also compared piroxicam with other nonsteroidal, anti-inflammatory agents. When compared with naproxen 250 mg *b.i.d.*, piroxicam 20 mg daily was significantly more effective in reducing pain at rest, pain at night and pain on motion. Also, those patients taking piroxicam showed advantages in measurements of general activity and overall assessment. In a study which compared piroxicam and indomethacin, one daily dose of piroxicam (20 mg) and high doses of indomethacin (100-200 mg) were both found to be effective in reducing the inflammatory signs of rheumatoid arthritis. However, in the same study, piroxicam showed advantages in decreasing the duration of morning stiffness and the number of joints painful on motion.

A key finding in all crossover studies and several open studies has been a strong patient and physician preference for piroxicam over other NSAI drugs. For example, in one study involving 749 patients conducted by 156 physicians, the physicians rated piroxicam as better than their patients' previous therapy in 72% of the cases.

Piroxicam is indicated for acute and long-term use in the treatment of both rheumatoid arthritis and osteoarthritis. It is contraindicated in patients who have previously exhibited hypersensitivity to it, or in individuals with the syndrome of nasal polyps, angioedema, and bronchospastic reactivity to aspirin or other anti-inflammatory agents.

As with other nonsteroidal anti-inflammatory agents, the most frequently reported side effects are gastrointestinal, occurring in approximately 20% of patients. In most instances, these effects were in the mild-to-moderate range and did not interfere with the course of therapy. This compares favorably with other nonsteroidal, anti-inflammatory agents: piroxicam generally has had fewer adverse effects than indomethacin, phenylbutazone or aspirin and was comparable to ibuprofen and naproxen.

Of the patients experiencing gastrointestinal side effects, approximately 5% discontinued therapy with an overall incidence of peptic ulceration of about 1%.

Piroxicam is highly protein bound and, therefore, might be expected to displace other protein-bound drugs. Although *in vitro* studies have shown this not to occur with dicoumarol, patients taking coumarin-type anticoagulants and other highly protein-bound drugs should be closely monitored when piroxicam is also taken.

The concomitant use of piroxicam and aspirin is not recommended. Plasma levels of piroxicam are depressed to approximately 80% of their normal values when piroxicam is administered in conjunction with aspirin (3900 mg/day). However, plasma concentrations of piroxicam do not appear to be significantly influenced by concomitant administration of antacids.

It is recommended that piroxicam therapy should be initiated and maintained as a single daily dose of 20 mg. If desired, the dose may be split and given twice daily. Dosage recommendations and indications for use in children have not been established.

Entertainment at a Convention Cocktail Party was provided by (left to right) Stan Brown, President of the Prince Georges/Montgomery County Pharmaceutical Association; Paul Freiman, Secretary of the Board of Pharmacy; and Dave Banta, MPhA Executive Director.

MPhA Past President Phil Cogan literally wore his professional occupation on his shirt at the Annual Convention Crab Feast.

David Banks, outgoing President of the University of Maryland Alumni Association, delivers remarks to the Alumni Association Annual Graduation Banquet.

Alumni Association President Angelo Voxakis addressed the future of the profession for the graduating pharmacy students at the banquet held May 27, 1982, in Baltimore.

Pictures courtesy Abe Bloom — District Photo

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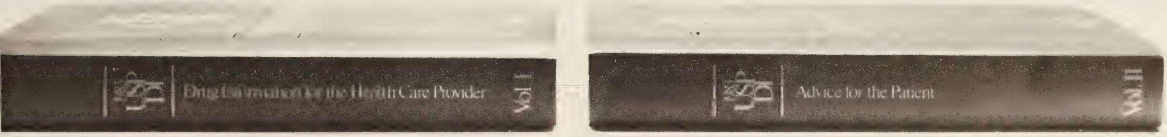

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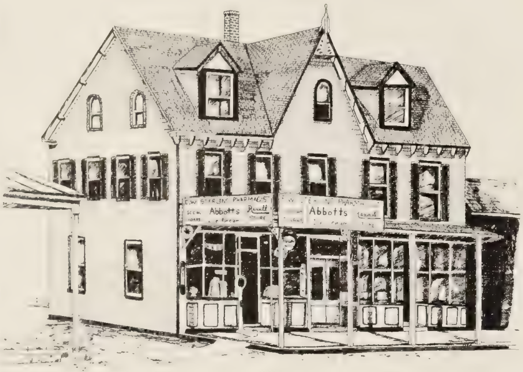

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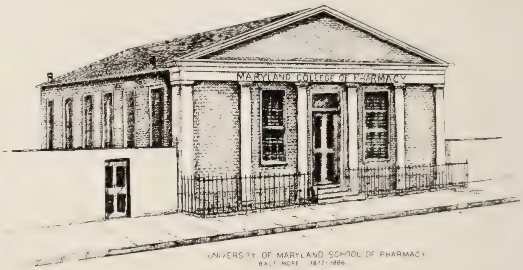

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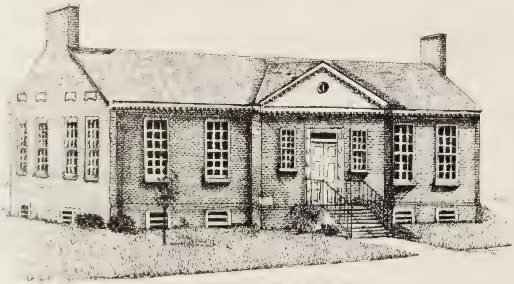

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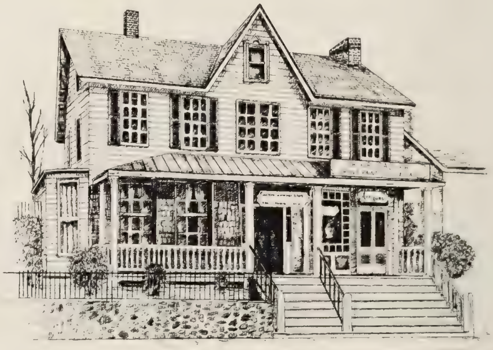

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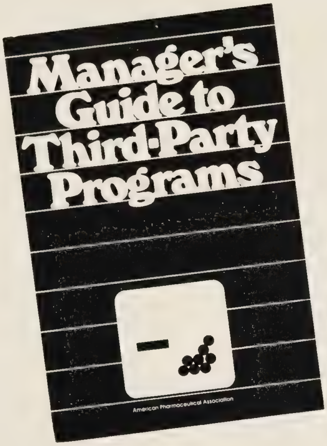
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ABSTRACTS

Excerpted from PHARMACEUTICAL TRENDS, published by the St. Louis College of Pharmacy; Byron A. Barnes, Ph.D., Editor and Leonard L. Naeger, Ph.D., Associate Editor

DANTROLENE:

Dantrolene (Dantrium) is a skeletal muscle relaxant that works in the skeletal muscle tissue itself by interfering with the excitation-coupling reaction. Since muscle activity is altered, it was suggested that its ability to decrease contractility might allow it to be an effective antiarrhythmic agent. Experiments conducted in isolated canine cardiac tissue indicate that this drug is capable of decreasing the contractility of cardiac tissue. It seems to mimic some action of verapamil and thus may have some value as an antiarrhythmic agent. *J Pharmacol Exp Ther,* Vol. 220, #1, p. 157, 1982.

PHENYTOIN-VALPROATE INTERACTION:

Sodium valproate (Depekene) is often used along with phenytoin (Dilantin) to control convulsive disorders not regulated by phenytoin itself. Valproate displaces phenytoin from binding sites on plasma protein and thus the plasma concentrations of the anticonvulsant will not accurately reflect its activity level since a higher proportion of the drug will be in the free, unbound active form. Studies conducted in 42 volunteers indicate that although plasma values of phenytoin are not valid indicators of the drug's effectiveness under these conditions, saliva samples do not vary with valproate administration and thus are preferred to plasma samples while monitoring phenytoin levels in patients receiving valproate. *Br Med J,* Vol. 284, #6308, p. 13, 1982.

METOPROLOL WITHDRAWAL:

Patients were maintained on metoprolol (Lopressor) at doses of 50 mg twice daily for six weeks and then the drug was withdrawn and replaced with a placebo preparation. All patients experienced an increased sensitivity to isoproterenol (Isuprel) and a 15% rebound rise in resting heart rate. Discontinuing the medication gradually (50 mg once daily for ten days) helped decrease the sensitivity to the adrenergic agent, but did not completely abolish it. The increased sensitivity may be due to an increase in receptor density which may occur in response to beta-adrenergic blockage. *Clin Pharmacol Ther,* Vol. 31, #1, p. 8, 1982.

PATIENT CONTROLLED ANALGESIA:

Patient-controlled analgesia (PCA) is a technique which allows a patient requiring constant narcotic analgesic therapy to titrate their own dosage as necessary. Patients have a device which can be activated as needed to supply a dose of the narcotic through an intravenous tubing. Initial results suggest that the patient using this device can regulate their analgesia without producing excessive side-effects, including drowsiness. These patients are also thought to have a reduced likelihood of becoming dependent on the narcotics. *J Am Med Assoc,* Vol. 247, #7, p. 945, 1982.

RAYNAUDS PHENOMENON:

A vasospasm of digital vessels may result in sensations of coldness in the hands known as Raynauds phenomenon. Captopril (Capoten) is a converting enzyme inhibitor used primarily to treat high renin hypertension, but recently it was found to also be effective in relieving the discomfort of Raynauds phenomenon. Since this alteration in temperature perception is not thought to be associated with excessive angiotensin II activity, it has been suggested that captopril exerts its beneficial effect by allowing for the accumulation of circulating kinins. The kinins produce vasodilation and increase perfusion through the extremity. *Br Med J,* Vol. 284, #6312, p. 312, 1982.

BODY FAT DISTRIBUTION:

The distribution of body fat above and below the waist may indicate the likelihood of diabetes mellitus development in women. Women who have more fat above the waist are more likely to have problems with carbohydrate intolerance than are those whose fat deposits are primarily in the hips, thighs, and buttocks. The fat cells in the lower part of the body have normal characteristics while those obtained from above the waist are generally enlarged, engorged with fat, and have a lower insulin receptor density. *J Am Med Assoc,* Vol. 247, #6, p. 731, 1982.

PROPRANOLOL DOSING:

Propranolol (Inderal) has been said to produce sustained beta-adrenergic blockade but only if given in four daily doses. In order to test this observation, the drug was used in doses of 80 mg twice daily or 40 mg four times daily. The plasma levels of 19 volunteers were monitored and after seven days of therapy it was concluded that the relative rate and extent of propranolol absorption was greatest after the twice-daily dosing schedule. In addition, the use of the drug in two daily doses also produced smaller variations in "area under the curve" calculations. Clinical studies will now follow to determine if patients requiring sustained beta adrenergic blockade can use propranolol in this manner. *J Clin Pharmacol,* Vol. 21, #11, p. 472, 1981.

1981 PRESCRIPTION AUDIT:

During 1981, Merck, Sharpe and Dohme and Smith, Kline and French Companies were the leaders in retail prescription sales volume. The drugs most often prescribed were Tagamet, Inderal, Valium, Motrin, Dyazide, Keflex, Clinoril, Aldomet, Naprosyn, and Lasix. *FDC Rep,* Vol. 44, #4, p. 6, 1982.

CAFFEINE AND ALCOHOL:

The intoxicating effects of ethanol have often been treated with coffee or other caffeine-containing beverages. A group of volunteers consumed a known amount of ethanol which was followed by a battery of psychophysical tests. They were then given either regular or decaffeinated coffee to drink and the tests were readministered. No evidence was found to support the concept that coffee or caffeine-containing beverages helped to counter the inebriation produced by ethanol. *Clin Pharmacol Ther,* Vol. 31, #1, p. 68, 1982.

DIURETIC THERAPY:

Hypokalemia can be a complication of thiazide therapy. Since the diuretics are often considered the drug of choice for mild hypertensive conditions, concern has been expressed that drug-induced hypokalemia might be more common than anticipated. Some drugs in this class have a longer duration of diuretic action than others, but evidence seems to indicate that the antihypertensive activity of these diuretics exceeds that of the diuretic response and probably lasts 24 hours regardless of the agent used. Experiments using hydrochlorothiazide (short diuretic action) and chlorthalidone (long diuretic action) indicate that the degree and incidence of hypokalemia is greater with the long acting drugs. It seems that small doses of short acting diuretics are the preferred treatment for mild hypertension. *Clin Ther,* Vol. 4, #4, p. 308, 1981.

LAETRILE:

Laetrile proponents have said the reason the substance is not always capable of exerting its "anti-cancer" effect was due to the fact that physicians waited until the disease reached an advanced stage before the drug was used. It has been suggested that laetrile (Amygdalin) may also be best used to prevent cancer. A study involving 187 patients with cancer indicated that no benefit was derived from laetrile therapy, even when accompanied by the recommended "metabolic" therapy consisting of diet, enzymes, and vitamins. Patients in the study were in good general health prior to start of therapy. No improvement or stabilization of neoplastic growth was noted in any patients receiving the regimen. The drug did produce symptoms of cyanide toxicity in several patients. Thus one more scientifically designed prospective study has failed to show benefit from laetrile administration. A growing body of clinicians feel that no benefit will be derived from this therapy. *N Engl J Med,* Vol. 306, #4, p. 201, 1982.

DMSO:

Dimethylsulfoxide (DMSO) is often used in a non-approved way to treat rheumatoid arthritis. The drug sulindac (Clinoril) is also used to help alleviate rheumatic pain so it is not surprising to find that some patients will use both drugs concomitantly. Sulindac is not active in itself, but must be converted into the active metabolite by enzymatic action. DMSO apparently inhibits the reduction of sulindac to its active component and thus interferes with its efficacy. Patients using sulindac should be cautioned to avoid DMSO. *Drug Metab Dispos,* Vol. 9, #6, p. 499, 1981.

SALICYLATE:

Many actions of the salicylates are due to the ability of the compound to inhibit cyclo oxygenase enzyme activity and thus decrease the synthesis of prostaglandins. Experiments were designed to determine if the activity on this enzyme resulted in the salicylate-induced enhancement of respiratory activity which is noted when the analgesic is ingested in large doses. Although salicylates did increase the respiration routinely in experimental models, other inhibitors of prostaglandin synthesis (e.g. indomethacin) had no such activity. The salicylate-induced effect is probably due to hypermetabolism of the respiratory regulatory tissue. *J Pharmacol Exp Ther,* Vol. 219, #3, p. 723, 1981.

ACETAZOLAMIDE:

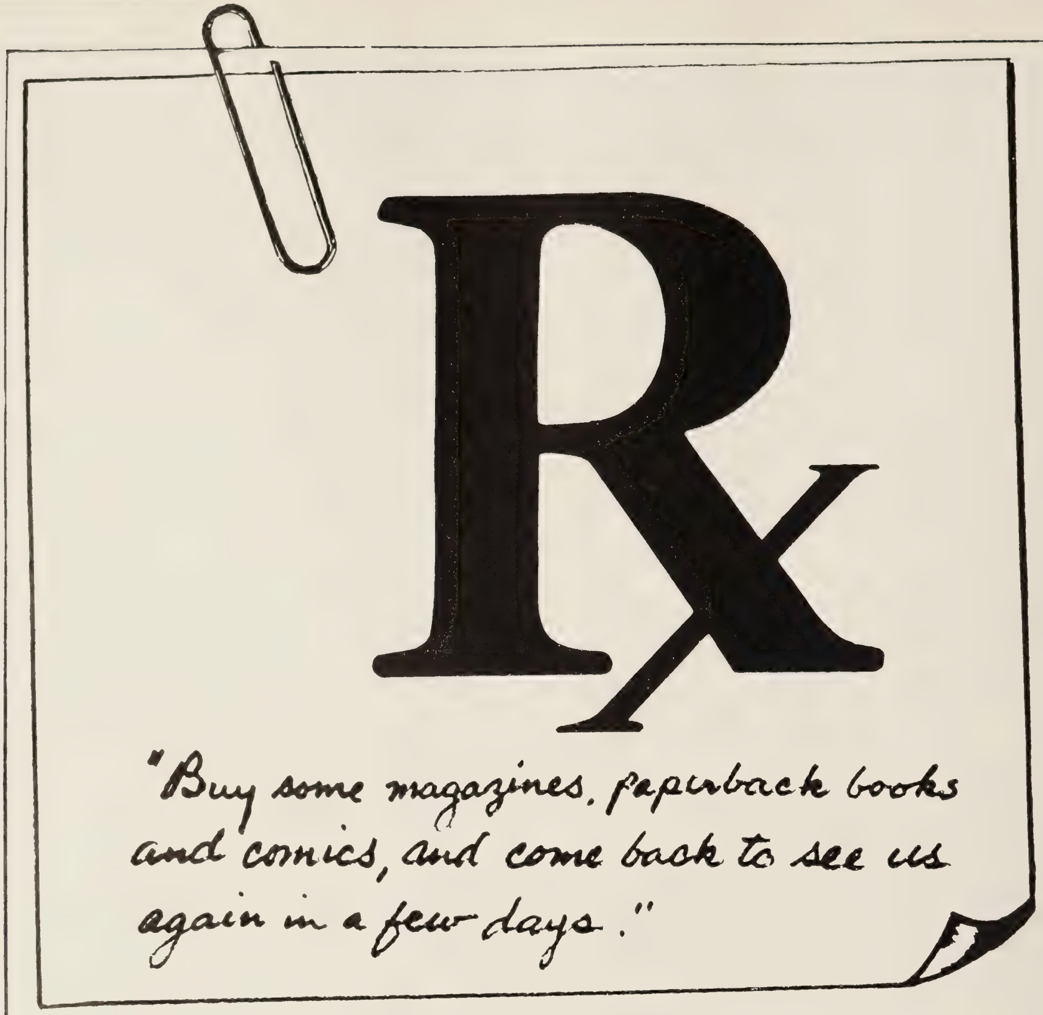
Acetazolamide (Diamox) is used in treating wide angle glaucoma, frequently on a long-term basis. The drug initially causes a loss of bicarbonate in the urine which subsequently produces a mild form of metabolic acidosis. Practitioners are cautioned to use acetazolamide with care in patients who have reduced renal function, especially the elderly. These people have an increased likelihood of developing systemic acidosis and may display the consequences associated with that imbalance. *Br Med J,* Vol. 283, #6305, p. 1527, 1981.

LEVOTHYROXINE:

Thyroxine is secreted from the thyroid gland to help regulate metabolic function throughout the body. As we age, the requirement for exogenous thyroid hormone in hypothyroid patients decreases. It has been suggested that elderly patients have a reduced need for levothyroxine because of a decreased catabolism of the hormone, but it is also possible that there is a reduction in thyroid requirement. *Ann Intern Med,* Vol. 96, #1, p. 53, 1982.

BENOXAPROFEN:

Another non-steroidal, anti-inflammatory drug (NSAID) is soon to be released for general medical use in this country. Benoxaprofen (Oraflex) has a longer duration of action than drugs currently in use. It needs to be administered only once daily. The drug is to be approved for rheumatoid and osteoarthritis. *FDC Rep,* Vol. 44, #4, p. 3, 1982.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calendar

Oct. 3—CECC Program on Cardiovascular Disease. Baltimore Hyatt.

Oct. 10–14—NARD Convention, Boston

Oct. 17—MPhA Dinner Theatre, Burne Brae, Music Man

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Nov. 4–7—SAPhA Regional Convention, Baltimore

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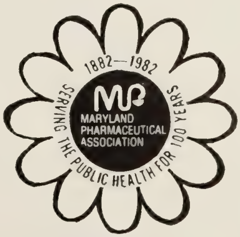
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October, 1982
VOL. 58
NO. 10

Drug Taking and Elderly — *Peter P. Lamy*

Some Facts and Myths About Vitamins

Reducing Shoplifting Losses

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President's Message

As President, I am given this space to comment on any of the many facets that touch pharmacy or our Association. I would like to give some well-deserved praise to a committee that probably should have more, the CECC (Continuing Education Coordinating Council). For those who do not know of it or do not know very much about it, the Council is a tripartite effort of the MPhA, the Maryland Society of Hospital Pharmacists and the School of Pharmacy. I am very proud to have served on this Committee for a space of time and know first hand the planning and hard work that goes into its programs. It is a group composed of members of each parent organization that meet on a continual basis, and more than most committees, putting together small and large continuing education programs for all of us. They have generally prepared four large programs, two or three small specialized programs and an on-going ''Road Show'' that moves around the State each year. Each program is visualized, planned and presented. Very simple to say, but complicated and time consuming to accomplish.

I am certain that all of us, whether we are community, hospital or consultant pharmacists, say to ourselves that we do not have enough time, or the Colts are playing, or some other rationalization so that we might make ourselves believe we can not attend these programs. It behooves all of us to remember that we picked this profession of Pharmacy as our life's work and, if we do not grow and continue to learn, we will stagnate and be replaced. The value is not just in what is derived from the programs themselves, but is also in the give and take of discussion with your peers that open new insights into professional and business decisions. Professional and trade journal reading will not suffice. Most of us are not disciplined enough to set allotted time aside for study.

Start now and initiate your own ''IRA'' (Individual Redevelopment Action). Set aside a small portion of your time to attend these educational meetings and give the Council the benefit of your thinking on future subjects. I am certain the Council is always searching for methods to fill a need in the profession.

Thank you CECC.

Milton Sappe,
PRESIDENT

Drug-Taking Behavior and the Elderly

by Peter P. Lamy

Drug therapy far too often ends in failure these days, especially among the elderly. Patient-practitioner encounters become disappointing and fruitless attempts at achieving therapeutic goals, leading to more frustration and failures and, finally, total lack of medical help.

The primary cause of these failures is lack of compliance. There is a complete failure to take medications in up to 50% of all cases, with varying degrees of noncompliance reported to range from 4–92%, depending on a number of variables.

To complicate matters, compliance is not a consistent behavior in a given individual; compliance with one regimen does not mean that a patient will automatically comply with another one.

Furthermore, scores of studies have proven that elderly patients make serious mistakes with their medicines because of confusion or forgetfulness.

Earlier reports were that, despite the time spent by the physician or pharmacist with elderly patients, their record of compliance was generally poor. More recently, however, encouraging reports are that elderly comply with treatment regimens to the same degree that younger patients do given the same amount of instruction. In fact, some studies show that some elderly patients demonstrate a surprising accuracy in self-administration of drugs.

The primary problem, of course, is that when elderly patients don't comply or don't use drug products correctly, the deleterious effects can be more severe than in younger patients. Psychiatric complications are not uncommon and can lead to the catch-all diagnosis of senility, further complicating the issue. Furthermore, many adverse effects result from an excessive dose or duration of drug use, both of which would be questioned by an informed patient.

Noncompliance can take many forms and has a number of causes, among which are:

* Using a drug incorrectly. Unit-dose drugs are sometimes taken unwrapped, the desiccant in prepackaged tablets is swallowed, not enough water is taken

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with bulk laxatives or aspirin, antacids are not chewed, or the drug is taken (not taken) with meals (milk, etc.).

* There are physical barriers to compliance. For example, many elderly patients have difficulty opening child-proof containers and do not realize that they may request containers that are not child-proof.

* The senses are not as sharp. Vision, hearing, touch, taste, odor, or color perception may be diminished and lead to a number of potential errors in medication-taking.

* Use of many drug products. Elderly average 4–7 different drug products used for chronic conditions, leading to greater chance of error. It is often suggested that drug regimens including more than four drugs are unsafe without close supervision.

* Written and/or verbal instructions are incomprehensible. Far too often the label is a collection of medical shorthand that takes the place of poor handwriting. Patient information sheets are not yet widely used. Auxiliary labels are used too seldom. And not enough verbal reinforcement is offered in the majority of cases. Studies indicate that instructions are frequently misunderstood and too quickly forgotten. Furthermore, great variations exist in the interpretation of both verbal and written instructions.

Potentially more hazardous is the common practice of writing "Take as directed," which places the total burden of both decision-making and recall on the patient, who may not have received directions in the first place. Even when this is coupled with verbal instructions, elderly patients often have more difficulty recalling verbal instructions, particularly when they are taking a number of drug products.

Patient Participation

It is not an easy task to identify the potential noncomplying patient beforehand. Noncompliance usually becomes apparent only after its effects become visible.

Clearly, one way of measuring noncompliance is through patient records. It is a good idea to keep close tabs on the records of all elderly patients to help them monitor their drug therapy. Elderly patients too often do not receive the attention they need. They have more problems and often require more time to give and receive information. Moreover, elderly frequently live alone or with another elderly person and do not receive close monitoring of their drug utilization. And, research shows, the duration of encounters between physicians and patients also declines with age.

The fact that a patient does not question instructions does not mean—and should not be understood to mean—that the patient understands them. Furthermore, the attitude that "the doctor will tell me what I need to know" still is encountered frequently among elderly patients.

How can patient compliance among the elderly be improved?

Many different programs and methods have been studied. Onset of illness type of illness, age, sex, education, social class, occupation, income, marital status, race and ethnicity, religion, and certain personality measures will have been investigated and found to lack correlation with compliance and behavior.

Moreover, there is no agreement as to the effect of patient surveillance. The social science literature seems to indicate that strong surveillance reduces compliance while the medical literature seems to support the opposite viewpoint.

Special packaging, special prescriptive containers, and the use of pill calendars all have been suggested, but compliance is not significantly improved with different packaging or memory aids alone which, at best, can only support compliant behavior.

The real answer would appear to be the development of self-management programs that actively involve the patient, coupled with strong patient education and continued reinforcement of verbal and written instructions by all health professionals.

Self-Management

Under section 504 of the federal Rehabilitation Act of 1973, a patient has the right to appropriate treatment and a right to refuse treatment. The rights were reinforced in 1978 by the President's Commission on Mental Health which established that freedom of choice is among the most basic principles of society.

Implicit within that context, however, is the concept that patients have enough information upon which to base a rational decision, a choice that can be made by an informed and aggressive patient. Yet, the aged often are not well enough informed nor aggressive enough to make such decisions. Fear and anxiety leads them to accept, even prefer to be told, the type of treatment (or no treatment) they should expect. They don't consider themselves as a necessary part of the treatment plan.

Both provider and patient have an important role in the ultimate outcome of appropriate drug use. The management of chronic diseases, prevalent among the elderly, demands a serious commitment by the patient to compliance with recommended regimens and cooperative interactions with the provider.

The importance of good provider-patient relations cannot be stressed too much. The patient must assume the role of aide-therapist, exchanging information with the provider, leading to more effective therapeutic regimens. The elderly must be taught and encouraged to become active partners in therapy and compliance, providing the physician and the pharmacist with information and, in turn, eliciting the information they need to ensure their drug therapy.

Pharmacists have a large role to play both with their individual patient and with the growing elderly community in general to convince them of their part in staying healthy and complying with drug regimens.

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Some Facts And Myths Of Vitamins

Vitamins are essential to human life, but their true role in the body and in nutrition is often misunderstood. This primer on vitamins explains what vitamins are and how they work.

Vitamins are organic compounds necessary in small amounts in the diet for the normal growth and maintenance of life of animals, including man.

They do not provide energy, nor do they construct or build any part of the body. They are needed for transforming foods into energy and body maintenance. There are 13 or more of them, and if any is missing a deficiency disease becomes apparent.

Vitamins are similar because they are made of the same elements—carbon, hydrogen, oxygen, and sometimes nitrogen. (Vitamin B_{12} also contains cobalt.) They are different in that their elements are arranged differently, and each vitamin performs one or more specific functions in the body.

In the early 1900's scientists thought that three compounds were needed in the diet to prevent beriberi, pellagra, and scurvy. Those compounds originally were believed to belong to a class of chemical compounds called amines and were named from the Latin *vita*, or life, plus amine—vitamine. Later, the "e" was dropped when it was found that not all of the substances were amines.

At first, no one knew what they were chemically, and they were identified by letters. Later, what was thought to be one vitamin turned out to be many, and numbers were added; the Vitamin B complex is the best example.

Then some were found unnecessary for human needs and were removed from the list, which accounts for some of the gaps in the numbers. For example, B_8, adenylic acid; B_{13}, orotic acid; and B_{15}, pangamic acid. Others, originally designated differently, were found to be the same. For example, vitamins H, M, S, W, and X were all shown to be biotin; vitamin G became vitamin B_2 (riboflavin); and vitamin Y became vitamin B_6 (pyridoxine, pyridoxal, and pyridoxamine). Vitamin M seems to have been used for three different vitamins—folic acid, pantothenic acid, and biotin. The present trend is to eliminate the confusion by using the chemical names.

Extremely sensitive methods of measuring the potency or quantity of vitamins have been developed because they are present in foods only in very small amounts. Some vitamins are measured in I.U.'s (international units), which is a measure of biological activity. This is necessary because these vitamins have several natural forms that have different activities on an equal weight basis. The others are expressed by weight in micrograms or milligrams.

To illustrate the small amounts needed by the human body, let's start with an ounce, which is 28.3 grams. A milligram is 1/1000 of a gram, and a microgram is 1/1000 of a milligram. The U.S. Recommended Daily Allowance (U.S. RDA) of vitamin B_{12} for an adult is 6 micrograms a day. Just one ounce of this vitamin could supply the daily needs of 4,724,921 people!

Getting enough vitamins is essential to life, although the body has no nutritional use for excess vitamins and some vitamins can be stored only for relatively short periods. Many people, nevertheless, believe in being on the "safe side" and thus take extra vitamins. However, a well-balanced diet will usually meet all the body's vitamin needs.

So-called average or normal eaters probably never need supplemental vitamins, although many think they do. Vitamin deficiency diseases are rarely seen in the U.S. population. People *known* to have deficient diets require supplemental vitamins, as do those recovering from certain illnesses or vitamin deficiencies.

People who are interested in nutrition and good health should become familiar with the initials U.S. RDA. "United States Recommended Daily Allowances" were adopted by FDA for use in nutrition labeling and special dietary foods. They are the highest amounts of vitamins, minerals, and proteins that are needed by most people each day.

The accompanying table lists the U.S. RDA's for vitamins used in nutrition labeling of foods, including foods that are also vitamin supplements. The table is not complete because it lists only vitamins. The complete table of U.S. RDA's also includes specific minerals and protein.

Vitamin A—Retinol

Vitamin A is an oil soluble vitamin like D, E, and K, and is stored in the liver. (Generally, oil soluble vitamins can be stored for long periods—even indefinitely—in the body. Water soluble vitamins are retained for short periods, if at all.) This vitamin is necessary for new cell growth and healthy tissues and is essential for vision in dim light. Besides resulting in reduced ability to see in dim light (night blindness), high sensitivity to light, and other eye maladies, vitamin A deficiency can cause dry, rough skin that may become more susceptible to infection.

Children and young people who have been given large doses of vitamin A have developed an increased pressure inside the skull that mimics symptoms of a brain tumor so convincingly that in several cases hospital personnel made preparations for surgery before the high intake of vitamin A was discovered. Carotene, a form of Vitamin A that occurs in plants is, on the other hand, practically nontoxic.

Vitamin A activity is found in foods in two forms: carotene, a yellow pigment in green and yellow vegetables and yellow fruits that the human body converts to vitamin A, and vitamin A itself, formed from carotene by other animals and stored in certain food tissues such as liver, eggs, and milk.

Vitamin B_1—Thiamin

This vitamin is water soluble, as are all in the B complex. Thiamin is required for normal digestion, growth, fertility, lactation, the normal functioning of nerve tissue, and carbohydrate metabolism.

Vitamin B_1 deficiency causes beriberi, a dysfunctioning of the nervous system. Other deficiency problems are loss of appetite, body swelling (edema), heart problems, nausea, vomiting, and spastic muscle contractions throughout the body.

Thiamin is abundant in pork, soybeans, beans, peas, nuts, and in enriched and whole-grain breads and cereals.

Vitamin B_2—Riboflavin

Riboflavin helps the body obtain energy from carbohydrates and protein substances. A deficiency causes lip sores and cracks, as well as dimness of vision. This vitamin is abundant in leafy vegetables, enriched and whole-grain breads, liver, cheese, lean meats, milk, and eggs.

Niacin

Niacin is necessary for the healthy condition of all tissue cells. A deficiency causes pellagra, which was once, next to rickets, the most common deficiency disease in the United States. Pellagra is characterized by rough skin, mouth sores, diarrhea, and mental disorders.

Niacin is one of the most stable of the vitamins, the most easily obtained, and the cheapest. The most abundant natural sources are liver, lean meats, peas, beans, enriched and whole-grain cereal products, and fish.

Pantothenic Acid

Pantothenic acid is needed to support a variety of body functions, including proper growth and maintenance. A deficiency principally causes headache, fatigue, poor muscle coordination, nausea, and cramps.

Pantothenic acid is abundant in liver, eggs, white potatoes, sweet potatoes, peas, whole grains (particularly wheat), and peanuts.

Folic Acid (Folacin)

Folic acid helps the body to manufacture red blood cells and is essential in normal metabolism which is, basically, the conversion of food to energy. A deficiency causes a type of anemia.

The most abundant sources are liver, navy beans, and dark green leafy vegetables. Other good sources are: nuts, fresh oranges, and whole wheat products.

Vitamin B_6—Pyridoxine—Pyridoxal—Pyridoxamine

Vitamin B_6 has three forms but all are used by the body in the same way.

This vitamin is involved mostly in the utilization of protein. As with other vitamins, B_6 is essential for the proper growth and maintenance of body functions. Deficiency symptoms include mouth soreness, dizziness, nausea, and weight loss, and sometimes severe nervous disturbances.

Pyridoxine is found abundantly in liver, whole-grain cereals, potatoes, red meats, green vegetables, and yellow corn.

Vitamin B_{12}—Cyanocobalamin

Vitamin B_{12} is necessary for the normal development of red blood cells, and the functioning of all cells, particularly in the bone marrow, nervous system, and intestines.

A deficiency causes pernicious anemia, and if the deficiency is prolonged, a degeneration of the spinal cord occurs.

Abundant sources are: organ meats, lean meats, fish, milk, eggs, and shellfish. B_{12} is not present to any measurable degree in plants, which means that strict vegetarians should supplement their diets with this vitamin.

Biotin

Once called vitamin H, biotin is now the sole descriptive term for this vitamin, which is actually a member of the B complex. It is important in the metabolism of carbohydrates, proteins, and fats.

Most deficiency symptoms involve mild skin disorders, some anemia, depression, sleeplessness, and muscle pain. A deficiency is extremely rare and this is probably because the bacteria in the intestinal tract produces biotin so that more is excreted than was consumed in the diet.

Abundant dietary sources include eggs, milk, and meats. *Raw* egg white contains a factor that destroys biotin.

Vitamin C—Ascorbic Acid

This least stable of the vitamins promotes growth and tissue repair, including the healing of wounds. It aids in tooth formation and bone formation. When used as a food additive, vitamin C acts as a preservative.

Lack of this vitamin causes scurvy, one of the oldest diseases known to man. The signs of scurvy include: lassitude, weakness, bleeding, loss of weight, and irritability. An early sign is bleeding of the gums and ease of bruising. Long before the 16th century, American Indians knew that scurvy could be cured by a tea made with spruce or pine needles.

Abundant sources are turnip greens, green pepper, kale, broccoli, mustard greens, citrus fruits, strawberries, currants, tomatoes, and other vegetables. You can get all the vitamin C your body needs by eating a daily 3- to 4-ounce serving of any of the foods named.

Vitamin D—Calciferol

This vitamin also exists in several forms. The most common (and equally effective) are ergocalciferol—vitamin D_2, and cholicalciferol—vitamin D_3. The D_2 is a plant source; the D_3 comes from animal sources.

Vitamin D aids in the absorption of calcium and phosphorus in bone formation. To accomplish its work, the body—through the liver and the kidneys—converts the vitamin to a hormone-like material.

Vitamin D deficiency causes rickets. The obvious signs are skeleton deformation—bowed legs, deformed spine, "potbelly" appearance, and sometimes flat feet and stunting of growth.

Too much vitamin D can cause nausea, weight loss, weakness, excessive urination, and the more serious conditions of hypertension and calcification of soft tissues, including the blood vessels and kidneys. Bone deformities and multiple fractures are also common. In fact, many of the symptoms from an excess of vitamin D are remarkably similar to those caused by a deficiency.

Abundant sources are canned and fresh fish (particularly the salt water varieties), egg yolk, and the vitamin D-fortified foods such as milk and margarine. People who spend part of their time in the sun with exposure of the skin need no other source of vitamin D, since it is formed in the skin by the ultraviolet rays. Foods fortified with vitamin D are intended mainly for infants and the elderly who lack exposure to sunlight. The daily requirement is very small and excess amounts above that are stored in the body.

United States Recommended Daily Allowances

	Unit	Infants (0-12 mo.)	Children under 4 yrs.	Adults and children 4 or more yrs.	Pregnant or lactating women
Vitamin A	IU	1500	2500	5000	8000
Vitamin D	IU	400	400	400	400
Vitamin E	IU	5	10	30	30
Vitamin C	mg	35	40	60	60
Folacin	mg	0.1	0.2	0.4	0.8
Thiamine (B_1)	mg	0.5	0.7	1.5	1.7
Riboflavin (B_2)	mg	0.6	0.8	1.7	2.0
Niacin	mg	8	9	20	20
Vitamin B_6	mg	0.4	0.7	2	2.5
Vitamin B_{12}	mcg	2	3	6	8
Biotin	mg	0.05	0.15	0.3	0.3
Pantothenic acid	mg	3	5	10	10

IU = International unit
mg = milligram
mcg = microgram

The U.S. RDA system was developed by FDA for its nutrition labeling and dietary supplement programs. This table for use in the labeling of dietary supplements lists only vitamin requirements, for the purpose of this article.

Vitamin K

There are several natural forms of vitamin K, which are essential to cause clotting of the blood. One type, K_1, occurs in plants. Another, K_2, is formed by bacteria in the intestinal tract. Yet a third is found in some animals and birds. The synthetic vitamin K, menadione, because of the potential for harm involved in its use, is dispensed only by prescription. Phyloquinone, K_1, may be used in dietary supplements up to a level of 100 micrograms per recommended daily quantity.

A deficiency causes hemorrhage and liver injury. Vitamin K is found in spinach, lettuce, kale, cabbage, cauliflower, liver, and egg yolk.

Vitamin E—The Tocopherols

Vitamin E in humans acts as an antioxidant that helps to prevent oxygen from destroying other substances. In other words, vitamin E is a preservative, protecting the activity of other compounds such as vitamin A. No clinical effects have been associated with very low intake of this vitamin in man. A rather rare form of anemia is premature infants, however, responds to vitamin E medication. A diet high in polyunsaturated fat requires a small increase in dietary vitamin E to prevent oxidation of this rather unstable form of fat.

Abundant sources are vegetable oils, beans, eggs, whole grains (the germ), liver, fruits, and vegetables.

Vitamin E is one of the most talked about vitamins, and to some extent the exaggerated and unsubstantiated claims made for vitamin E result from a combination of hope and misinterpretation.

The Committee on Nutritional Misinformation of the National Academy of Sciences has issued a report on vitamin E. Three statements are quoted here:

"Surveys of the U.S. population indicate that adequate amounts of vitamin E are supplied by the usual diet."

"Careful studies over a period of years attempting to relate these (test animal) symptoms to vitamin E deficiency in human beings have been unproductive."

"Self-medication with vitamin E in the hope that a more or less serious condition will be alleviated may indeed be hazardous, especially when appropriate diagnosis and treatment may thereby be delayed or avoided."

Most of us view scientific knowledge with awe, and we are quite justified, considering the scientific achievements of our age. Misconceptions about vitamins and their proper functions are understandable; no primer would be complete that fails to clear up some of these misconceptions:

Myth:	***Organic or natural vitamins are nutritionally superior to synthetic vitamins.***
Fact:	*Synthetic vitamins, manufactured in the laboratory, are identical to the natural vitamins found in foods. The body cannot tell the difference and gets the same benefits from either source. Statements to the effect that "Nature cannot be imitated" and "Natural vitamins have the essence of life" are without meaning.*
Myth:	***Vitamins give you "pep" and "energy."***
Fact:	*Vitamins yield no calories. They, of themselves, provide no extra pep or vitality beyond normal expectations, nor an unusual level of well-being.*
Myth:	***The more vitamins the better.***
Fact:	*Taking excess vitamins is a complete waste, both in money and effect. In fact, as noted, excess amounts of some vitamins can be harmful.*
Myth:	***You cannot get enough vitamins from the conventional foods you eat.***
Fact:	*Anyone who eats a reasonably varied diet of whole food, should normally never need supplemental vitamins.*

The abundant sources listed give some idea of how difficult it is to be undernourished from lack of vitamins.

Each of the following is not only an abundant source of one or more vitamins, but also contains important amounts of most of the rest of the nutrients:

Liver; eggs, cheese; fortified margarine; butter; whole milk; fortified milk; fish; egg yolk; yellow vegetables; green leafy vegetables; yellow fruits; beans; peas; nuts; whole-grain foods; red meats; lean meats; pork; shellfish; fresh vegetables; white potatoes; sweet potatoes; yellow corn; rice; strawberries; currants; citrus fruits and juices; tomatoes and juices; other fruits, juices, and berries; canned and fresh herring; salmon; tuna; lettuce; fresh oranges; cabbage; spinach; cauliflower; and vegetable oils of several kinds.

Even though the widely seen and identified vitamin deficiency diseases of 30 years ago have all but disappeared, the American consumer is approached from all sides with misinformation about the almost universal "need" for supplements of vitamins.

Is there really a need? Each person can answer this only after examining his or her regular diet and learning what vitamins can and cannot do.

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Reducing Shoplifting Losses

by Addison H. Verrill

Summary

Shoplifters and magicians have one thing in common. Both rely on sleight-of-hand. However, amusement turns to anguish when individuals who pretend to be customers come into a small store and prove that "the hand is quicker than the eye." The methods which shoplifters use are discussed in this paper, and the types of persons who practice this form of thievery are described. The paper also gives practical suggestions on using protective devices, on what employees must do, and on apprehending and arresting shoplifters.

The author is president of Dale System Incorporated, New York, N.Y.

Shoplifters are stealing me blind, is a complaint made by many retailers. And rightly so, because in some localities the shortages caused by nimble-fingered artists are the greatest percentage of a retailer's inventory shrinkage.

Unfortunately, there is no easy way to break up such thievery. It is a constant battle in which you must fight individual engagements. One difficulty is identifying your opponent. Challenging an innocent person can be costly as well as embarrassing.

A key to reducing shoplifting losses is knowning your man and catching him in the act. What methods are used by the shoplifter? What kind of person is he?

Methods of Shoplifters

Professional shoplifters are sleight-of-hand experts. Under ordinary circumstances, they can, and do, snatch items from counters and pass these items to confederates without detection.

The best protection a retailer has is a sales force trained to watch for such things. In stores where clerks are not wide awake, shoplifters can literally take over. These thieves have been known to step behind counters, pose as sales clerks, and collect money from customers.

As for the hand-is-quicker-than-the-eye techniques, shoplifters come equipped with coats and capes which have hidden pockets and slits or zippered hiding places. Hands emerge unseen from slits to snatch up articles directly from open displays. Many times, such performances are blocked from view by the open coat itself. These shoplifters are also adept at palming small items with the cover-up aid of loose handkerchiefs and gloves.

Sometimes shoplifters have special hooks or belts on the insides of their coats or tricky aprons and undergarments designed to hold innumerable articles. Some sleight-of-hand thieves slip merchandise into packages or into boxes that have a hinged top, bottom, or end. Salesclerks should know how to spot such devices. Employees should also be suspicious of and watch shoppers who carry bulky packages, knitting bags, shopping bags, and umbrellas. These are handy receptacles for items which a shoplifter *purposely* knocks off counters.

Some shoplifters do not confine their activity to shopowners. They even steal from customers. They pick up packages or handbags which store patrons carelessly lay aside in their preoccupation with shopping.

Ticket switching is another method used by shoplifters. It is an especially vexing problem for owner-managers of a store. It is almost impossible to prove the guilt of a ticket switcher, for one thing. Also there is the hazard of false arrest countercharges.

Types of Shoplifters

Fortunately for the owner-manager of a small store, the majority of shoplifters are amateurs rather than professionals. A breakdown of various types should help you to understand the motives which cause these individuals to steal and the methods they use.

JUVENILE OFFENDERS. The young make up about 50 percent of all shoplifters, and indications are that this type of offender is on the increase. Sometimes youngsters steal "for kicks" or because they have been "dared" to do so. They may enter stores in gangs. In order to discourage these rebellious and unsupervised juveniles, retailers should "get tough." Youth is no excuse for crime. It should be prosecuted and made to pay through the proper legal channels.

HOUSEWIVES. Many retailers report that the majority of adults who are apprehended are women, and a significant number of them are housewives. They steal because they have given in to momentary impulse and temptation. Many of them are first offenders and by catching them, you may help prevent them from becoming habitual shoplifters.

KLEPTOMANIACS. Thefts by kleptomaniacs stem from psychological compulsions. The term is a combination of the Greek word for thief, "kleptes," and the word "maniac." Often kleptomaniacs do not need the items they pick up. But even so their behavior is no less costly to you.

DRUNKARDS AND VAGRANTS. Drunkards and vagrants are probably the most clumsy shoplifters and the easiest to detect. They often steal because they desperately need money and food.

NARCOTICS ADDICTS. Drug addicts are, of course, more desperate than vagrants. Also addicts may be armed. They should be handled by the police.

PROFESSIONAL SHOPLIFTERS. The professional is the most difficult type to detect and apprehend. He is clever at his craft. When he comes into the store, he often pretends that he is shopping for something to buy for his wife.

The professional shoplifter is "in business" for money. He usually steals to resell his loot to established fences. He often has a police record. Indeed, he may belong to an underworld organization which will supply bail and help him in court.

The professional can be discouraged from stealing if he sees that store personnel are really alert.

Call the Police

Regardless of the type of shoplifter, the common answer that most shoplifters give when caught is: "I have never done this before."

Failure to prosecute "first offenders" encourages shoplifting. It is best to operate on the premise that he who steals will also lie. Call the police when you catch a shoplifter.

When every merchant in town follows the policy of prosecuting each shoplifter, the word gets around. Hard-

ened professionals will avoid the town. Amateurs will think twice before yielding to the temptation to pocket a choice item.

Protective Personnel and Devices

In reducing shoplifting losses, the deterrent factor is all important. Protective devices help you to discourage borderline shoplifters—ones who don't steal unless the coast is clear—and to trap bold ones. Among these devices are two-way mirrors, peepholes, closed-circuit television, radio communication, and detectives posing as customers.

Some large stores use uniformed guards and plainclothes personnel who serve as a reminder to patrons that only legally purchased merchandise may be removed from the premises. One way to identify such merchandise is to use stapled packages with receipts attached outside.

When you have no guards and rely solely on your own people, convex wall mirrors can be helpful. They allow store personnel to see around corners and keep several aisles under observation from regular work stations.

Anti-shoplifting signs prominently displayed warn potential thieves and deter some. Various uses of public address systems have also been employed to discourage shoplifters. When a suspect has been observed, a ''walkie-talkie'' radio can be used for speedy communication between you and those employees who handle such situations.

Electronic devices which expose the shoplifter are also on the market. One example of such a device is an electronic pellet or wafer attached usually to an expensive garment so that it cannot be removed without tearing the merchandise. If a shopper tries to remove the garment from the store, the pellet or wafer sends out signals. The cashier removes the pellet with special shears when the customer purchases the garment.

You should keep in mind that there is a legal danger in using electronic devices. If the cashier forgets to remove the pellet device, an innocent shopper may be stopped outside and falsely detained.

When shoplifters use ticket switching to gain their ends, you can use the following alternatives:

(1) *Tamper-proof gummed labels* which rip apart when attempt is made to remove labels.

(2) Hard-to-break *plastic string* for softgoods tickets.

(3) When tickets are stapled on, *special staple patterns* are used which are recognizable to store personnel.

(4) *Extra price tickets* are *concealed* elsewhere on merchandise.

If you use simple and basic pricing methods, don't ticket prices in pencil. Use a rubber stamp or pricing machine.

Physical Layout of Stores

A store's layout can discourage or encourage shoplifting. For example, high fixtures and tall displays which give visual protection to the shoplifter will encourage his practices. To destroy such protection, set your display cases in broken sequences. If possible, run them for short lengths with spaces in between.

Keep small, high-priced items out of reach, preferably in locked cases. Keep valuable and easy-to-hide items at counters where clerks are in continuous attendance. Or better yet, let the customer ask a salesman to show him such items.

If fire safety regulations allow it, lock all exits not to be used by customers. In addition, attach noise alarms to the exits which must be kept unlocked. Always close and block off unused checkout aisles.

What Employees Must Do

Employees must watch merchandise and people if you are to prevent shoplifting. Generally, your salesclerks should be alert to persons who wear loose coats or capes or bulky dresses. They should also watch persons who carry large purses, packages, umbrellas, and shopping bags. Those who push baby strollers and collapsible carts also bear watching as well as individuals who walk with short steps. The latter may be carrying stolen goods between their legs.

In clothing stores, clerks should beware of the ''try-on'' shoplifters. They try on an item for size, as it were, and then, if they feel no one has seen them, walk out wearing the garment. Salespeople should keep a check on the number of garments carried into the fitting

rooms. Thieves often try to sneak in extra garments beyond the number permitted.

You and your people should be especially alerted for "teams"—thieves who pretend not to know each other. One of the team will attract the clerk's attention away from the partner. He will cause a fuss, ask unreasonable questions, create an argument, even stage fainting fits while his partner picks up the merchandise and makes a quick exit.

Sales persons should keep in mind that ordinary customers want attention while shoplifters do not. When busy with one customer, the salesman should acknowledge other customers with polite remarks such as, "I'll be with you in a minute." It can make a shoplifter feel uneasy. Such attention pleases ordinary customers.

Salesclerks should not give the impression that they distrust customers, but they must always be alert to their movements. If possible, they never should turn their backs to customers even when fetching merchandise for them. They should display merchandise neatly because missing items are easily detected when orderly arranged.

You should schedule your employees' working hours with floor coverage in mind. An adequate number of clerks should be on duty during your store's busy periods. These periods are most conducive to theft.

Finally, and most important, you should instruct employees about what they are to do when they observe a theft by a shoplifter. This training should be done periodically, at least once every 3 months. Such knowledge helps prevent legal problems in addition to catching offenders.

Apprehension and Arrests

Be certain or risk a false arrest suit is a good rule to follow when catching a shoplifter.

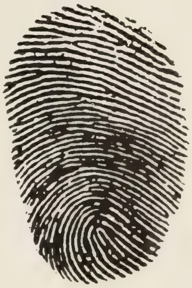
In pursuing this rule, salespersons should not accuse patrons of stealing. Nor should they try in any way to apprehend shoplifters. When a salesperson sees what appears to be a theft, he should keep the suspect in sight and alert you immediately. The police or the store detective should be notified if you use one. In fact, salespersons should alert you about any suspicious loiterers.

If your refund desk clerk receives a returned item and recognizes it as a stolen or suspicious item, she should delay the person and call you. Ask the person for identification and have him sign his name and address. If the item is stolen, he will usually give a wrong name and have no identification.

Some organizations in large cities have control files on shoplifters who have been caught. Your retail merchant's association can inform you about the services available in your area. You can check these files to see whether the person you catch has a record. Usually a shoplifter claims to be a first offender. He is apt to remain a "first offender" if the merchant allows him to leave without positive identification and without filing his name with the police and local retail merchant association.

You should also check to see what the law is in your State. Many States have passed "shoplifting laws" which, among other things, deal with apprehending shoplifters. Check with you lawyer or the police in your area.

GENERAL RECOMMENDATIONS. It is best to apprehend shoplifters outside of the store. For one thing, apprehension of this kind strengthens the store's case against a shoplifter. Then, too, scenes or any type of commotion which a shoplifter precipitates interferes with store operation.



You should recognize that apprehension in many States does not necessarily have to be initiated outside of the store. Sometimes, it suffices if a shoplifter is observed concealing merchandise on his or her person. A shoplifter is generally apprehended in the store if the merchandise involved is of substantial value, and if you feel that he may get away with the stolen goods if you allow him to get beyond the store premises.

If the shoplifter is an elderly person, treat him or her with extra gentleness lest he be "shocked." If you don't, he may have a heart attack. A good approach to stopping a suspect is to speak to him and identify yourself. Then say: "I believe you have some merchandise on your person or in your bag which you have forgotten to pay for. Would you mind coming back to the store to straighten out this matter?" Never touch the suspect because the contact could be construed as roughness.

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'Tween Scripts

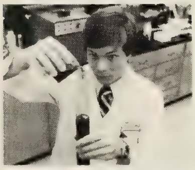
By Jake Miller, Pharmacist
Manager, Professional Relations
A. H. Robins Company, Inc.

Non-Traditional Internship Experiences

With the passing of summer, we have completed our 10th year of participation in the National Pharmaceutical Council—Pharmaceutical Industry Summer Internship Program. A. H. Robins was one of 22 manufacturers taking part in the 1982 program conceived by the NPC and the Student American Pharmaceutical Association. The three interns who spent their summer with us were among 87 students selected from 46 schools.

Each participating company sets up its own program, with most consisting of rotation assignments offering professionally supervised hands-on experience in several departments. At A. H. Robins, each works 10 weeks in such areas as research and development, quality assurance, production and marketing.

In addition to making students more aware of the many jobs pharmacists perform in industry, this Program provides an opportunity to gain a greater appreciation for everything that goes into the making of a drug. Thus, the students will be better prepared to make intelligent decisions regarding drug sources when they become practicing pharmacists and will be better able to explain the issue of drug quality to their patients.



Intern Brian Bullock at work in an A. H. Robins lab. Bullock is current president of the Student A.Ph.A.

The program is one of several which seeks to identify non-traditional areas of professional pharmacy practice. Other areas which may qualify for internship credit include hospital pharmacy programs developed by the VA; the U. S. Public Health Services' COSTEP Training program; national or state pharmaceutical association internships; and participation in research programs conducted under the auspices of manufacturers, colleges or governmental agencies which provide a learning experience comparable to professional practice and which earn no academic credit.

As we have followed the careers of former NPC/Industry interns, we have become firmly convinced that the experience has been beneficial and we are proud to have had a part in their professional development.

Jake Miller

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Though not dramatic, the use of pharmacy computer systems is continuing its steady growth. In a little more than a year, two dozen new firms have come into the marketplace, while a significant number have left this increasingly crowded field. The American Pharmaceutical Association's (APhA's) Pharmacy Management Institute has identified about 90 primary suppliers who have several hundred offices throughout the country.

Pharmacy managers continue to fill computer system conferences to capacity. There does not, however, seem to be the degree of skepticism that was evident before as pharmacy managers continue their search for a solution to paperwork headaches and the cost-price squeeze. This change in thinking is probably a result of more information being available in the form of conferences, articles in the literature, and the emergence of *Computer Talk for Pharmacists,* a relatively new source of pertinent information on pharmacy computer systems.

APhA has a long-term interest in pharmacy systems and has been of major service to pharmacists by presenting programs on computers, providing information to members, and advising computer vendors on how to design their systems and service networks in response to pharmacists' needs. The Pharmacy Management Institute has updated and consolidated its popular computers bibliography. This comprehensive list has been requested by more than 3,000 and is available without charge from the APhA Pharmacy Management Institute, 2215 Constitution Avenue, NW, Washington, DC 20037, by sending a stamped, self-addressed envelope.

APhA is the national professional society of pharmacists. Its more than 50,000 members represent practitioners in a variety of settings, pharmaceutical scientists, pharmacy educators, and pharmacy students.

calendar

November 4–7—SAPhA Regional Convention, Baltimore
November 7—"OTC Counseling" Crystal City, Marriott
November 14—"Diabetes" Columbia Hilton, CECC Program
November 14—Alumni Association Dinner Meeting
November 30—"Vitamin Marketing" Atlantic City, New Jersey
February 13—BMPA Dinner Dance
March 13—"Communications and the Elderly" Center for Aging, MPhA
March 27—"Arthritis" Ramada Inn, Baltimore, CECC Program

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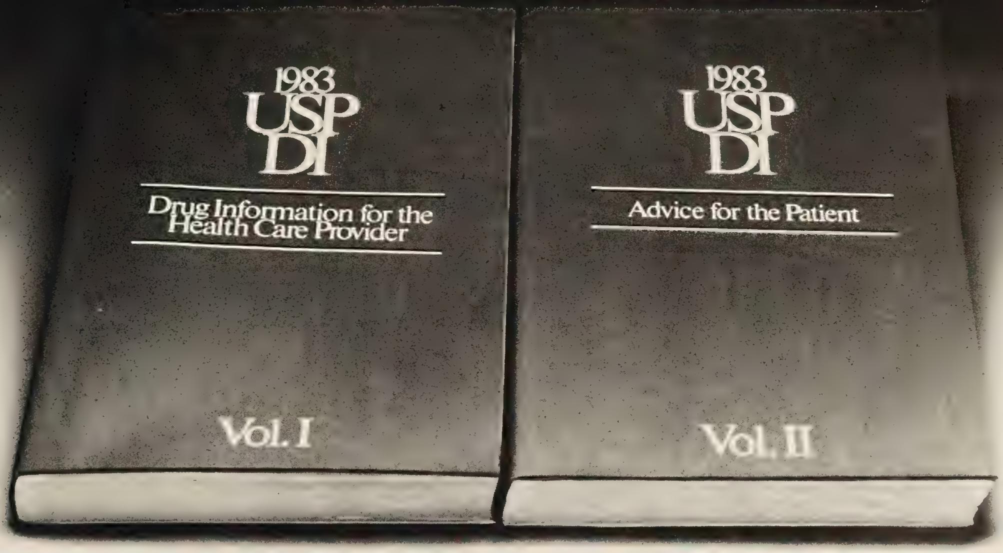

THE 1983 USP DI, NOW IN TWO VOLUMES.

Now more than ever, patients are turning to their pharmacists for advice about drug products. That's why more pharmacists around the country turn to *USP Dispensing Information (USP DI)* as the definitive reference for drug use information. Now the United States Pharmacopeia is offering a newly expanded and updated edition, available for the first time as a two-volume set.

Volume I, designed for use by the pharmacist, contains detailed dispensing information on over 4,500 drug dosage forms and brands. Volume II is a corresponding lay language guide for patients with instructions on the proper use, precautions and side effects of their medicines.

In addition to the new two-volume *DI*, USP is offering the consumer paperback *About Your Medicines* and a free kit of advertising and publicity tools to help you promote your patient education program. To order your copies, just mail in the coupon below.

MAIL TO: **Maryland Pharmaceutical Association**
650 W. Lombard Street
Baltimore, Maryland 21201

Please send me the following:

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________ 1983 *USP DI*, each complete two-volume set, $37.95.*

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________ *About Your Medicines* Consumer Display Kit (12 lay language paperback books packaged in counter-top display box), $36.00. (Suggested retail price $4.95.)

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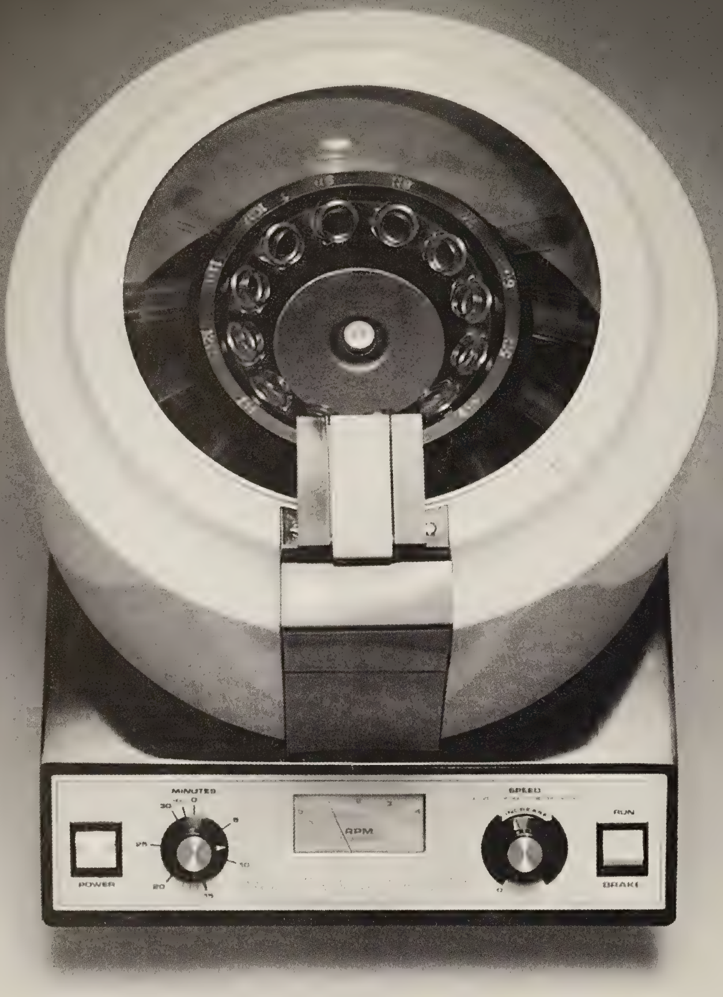

Research Roulette

In 1981, the cost of developing a new chemical entity was $77 million. Yet, three out of four new chemical entities marketed never recapture their R & D investment.

Surprising? Yes. But, the real surprise is that today's drugs consume only 8 percent of all health care costs as compared with 16 percent 40 years ago.

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LETTERS

Dear Mr. Banta:

The Following is a continuing education conference being conducted by the Medical College of Virginia, School of Pharmacy.

"Management of GI Disorders in the Elderly"
Sunday, November 21, 1982
Hotel Roanoke
Roanoke, Virginia

CONTACT: Dr. Werner Lowenthal, Director
Continuing Education
School of Pharmacy
(804) 786-0334

We would appreciate having this announcement published in your next issue of your journal.

Thank you for your assistance.

Sincerely,
Werner Lowenthal, Ph.D.
Director, Continuing Education

To the Maryland Pharmaceutical Association,

Thank you once again for your continued support of SAPhA. We greatly appreciate all that you have done for SAPhA in the past and look forward to working with you in the future.

Each of the students attending the convention learned many things about their future profession and themselves.

Thank you again for your support.

Sincerely,
Cheryl L. Betz
President SAPhA

Dear Mr. Banta:

Since you previously contacted the Presidential Task Force on Regulatory Relief concerning patient package inserts (PPI's), the Vice President has asked me to advise you that the Food and Drug Administration has issued a final rule effective today revoking these requirements.

This action is being taken because the agency has determined that a mandatory pilot PPI program is unjustifiable, and that it is now preferable to encourage alternative patient information efforts. The agency also believes that cooperation with health professionals and others in both the public and private sectors and reliance upon expanding privately sponsored initiatives in patient education will serve to provide patients with needed information about prescription drugs.

On behalf of Vice President Bush, may I again thank you for making your views known to the Task Force on this important issue.

Sincerely,

C. Boyden Gray
Counsel to the Vice President

Tel Med Cancer Series

One out of every six deaths in America this year will be caused by cancer. But Marylanders will soon be receiving extra help in learning how to prevent, detect and treat the disease. Seven Maryland Tel-Med free telephone health information programs are featuring special messages directing callers to contact the Cancer Information Service at Johns Hopkins Oncology Center.

The Cancer Information Service is sponsoring the pilot project using the Tel-Med communication network in Maryland to disseminate information about the availability of additional cancer resources to the public. Through the service callers will be able to receive information about cancer causes, prevention, early detection, treatment, rehabilitation and referral to cancer related agencies and services.

To receive the information, callers should ask for the following Tel-Med tapes by number: 6-Breast Cancer, 176-Cancer of the Prostate Gland, 179-Lung Cancer, 180-Cancer of the Colon & Rectum, 181-Cancer the Curable Disease, 183-Cancer's Seven Warning Signals, 185-Cancer of the Skin, 186-Uterine Cancer, 5021-Cancer Information Service.

The numbers to call in Maryland are:

Allegany County: Sacred Heart Hospital, 777-8383
Baltimore: University of Maryland Hospital, 528-3111
Provident Hospital, 728-2900
Lower Shore: Peninsula General Hospital in Salisbury (after October 1, 1982)
Montgomery County: Shady Grove Adventist Hospital, 424-7500
Prince George's County: Prince George's Library, 345-4080 or TTY for the deaf, 345-0800
Upper Shore: Memorial Hospital at Easton, 822-9198

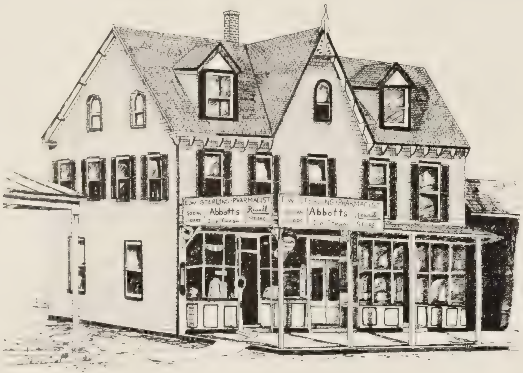
Short and sweet is better than long gone

Often the more words you write, the less clear your message becomes. Take for example, this list, compiled by *Grassroots,* of the number of words in these writings from the past.

- The Lord's Prayer, 56 words.
- The Gettysburg Address, 266 words.
- The Ten Commandments, 297 words.
- The 23rd Psalm, 118 words.
- The 1966 U.S. Government Order on Cabbage Prices, 26,911 words.

Art Prints Available Maryland Pharmacy History

The Centennial Committee of the Association has commissioned a limited set of art prints depicting historical sites in Maryland. These prints by noted artist Marian Quinn are each hand numbered and signed by the artist. The prints are available from the Association Office at $7.50 each or four for $25.00. They are ink line drawings that are certain to be collectors items in the future.



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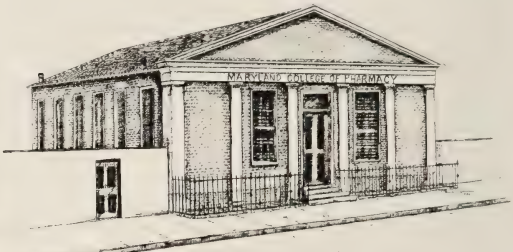

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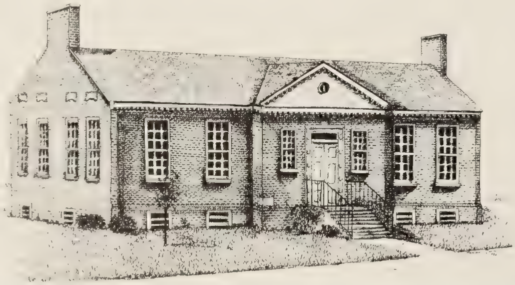

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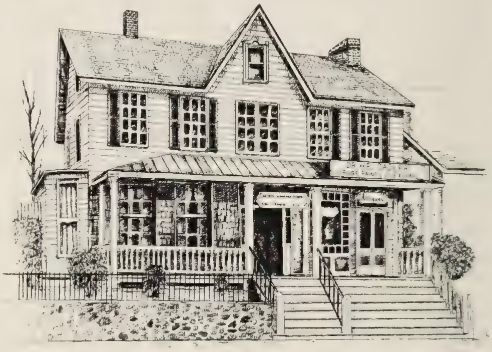

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(Prints are $7.50 each or four for $25.00)
Mail this form and check made payable to MPhA to 650 West Lombard St., Baltimore, Maryland 21201.

Pharmacists, Clergy Rated Highest on 'Ethics Scale'

By George Gallup

Clergymen and pharmacists are rated highest by the public in terms of ''honesty'' and ''ethical standards'' among 24 professions and occupations tested.

These findings are based on the third Gallup study of public perceptions of the ethics of persons in a wide range of professions. This question has been asked in each survey:

> *How would you rate the honesty and ethical standards of people in these different fields – very high, high, average, low, or very low?*

While certain professions or occupations do not fare too well in these studies, it is important to bear in mind that these findings reflect public perceptions only and are not necessarily a true indication of the ethical standards of a particular group.

At the same time, however, the findings suggest the need for a strong public relations effort on the part of certain professions or occupations.

Clergy Again Top List Next Are Pharmacists

Clergymen, as in the two earlier surveys, come out on top of this ''ethics scale,'' with 63% of persons in the survey giving them either a very high or high rating.

Next are pharmacists with a positive range of 59%.

Following closely are dentists, medical doctors, engineers, college professors, and policemen, with overall positive ratings ranging from 52 to 44%.

The next highest groups include bankers, TV reporters or commentators, newspaper reporters, and funeral directors, with positive scores ranging from 39 to 30%.

Maryland Pharmaceutical Association

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Beverly Litsinger, MPhA Office Secretary, works with the new word processor recently purchased by the Association. The machine will improve staff efficiency and allow the Association to provide better service to the members.

BMPA President Frank Marinelli discusses plans with SAPhA President Cheryl Betz.

BMPA President Marinelli (right), SAPhA Chapter Advisor Donald Fedder (center), and BMPA President-Elect Elwin Alpern, were among those who attended the September 7th SAPhA Luncheon. The event was sponsored by the BMPA as part of a membership recruitment drive by the student organization.

Held in the Kelly Building, the Luncheon produced a record turnout of students, faculty and friends.

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ABSTRACTS

Excerpted from PHARMACEUTICAL TRENDS, published by the St. Louis College of Pharmacy; Byron A. Barnes, Ph.D., Editor and Leonard L. Naeger, Ph.D., Associate Editor

ASPIRIN:

Aspirin remains the drug of choice for treating rheumatoid arthritis. Although the drug certainly causes gastrointestinal distress, its effect on the renal system over a long period of time is less clear. Studies from various sources tend to clear aspirin of causing renal damage, even when used for prolonged periods. Renal toxicity is more apparent when agents such as phenacetin are used with the salicylates. *J Am Med Assoc,* Vol. 247, #1, p. 55, p. 63, 1982.

LEGIONNAIRES DISEASE:

Since it was originally characterized in 1976, much of the information concerning Legionnaires disease has been obtained by studying patients with the disease. The organism responsible for causing this condition, Legionella pneumophilia, does not infect animal lungs as it does the human respiratory tissue; thus animal experimentation is minimal. Furthermore, when injected intraperitoneally the organism does not infect respiratory tissue so only extrapulmonary sites of infection can be studied. Experiments recently conducted indicate that respiratory infections similar to those seen in human lung tissue can be induced in guinea pigs using aerosols containing the organism. This allows for suitable experimental animal models to be used to study the effect of this organism in respiratory tissue. *Lancet,* Vol. II, #8260, p. 1389, 1981.

NSAID:

Drugs belonging to the group designated as nonsteroidal, anti-inflammatory drugs (NSAID) are thought to have many similar pharmacological effects due to their common ability to inhibit the synthesis of prostaglandins. Experiments in animals indicate that these agents may have different effects on regional circulation. For instance, mesenteric vasculature is constricted by indomethacin (Indocin) but not by ibuprofen (Motrin). The authors hypothesize that the action of indomethacin is characteristic of the drug itself and is not due to its ability to inhibit prostaglandin synthesis. *J Pharmacol Exp Ther,* Vol. 219, #3, p. 679, 1982.

IBUPROFEN:

Ibuprofen (Motrin) is a potent inhibitor of prostaglandin synthesis. Since prostaglandins have been said to have a role in regulation of coronary artery tone, this NSAID was examined in perfused animal heart tissue to see if it might have an effect on coronary flow. It appears that ibuprofen will cause coronary dilation but it acts in a way not associated with inhibition of prostaglandin synthesis. *J Pharmacol Exp Ther,* Vol. 220, #1, p. 167, 1982.

GUANABENZ:

Guanabenz is an experimental antihypertensive agent which acts centrally to reduce adrenergic outflow from the central nervous system. The drug does not cause volume expansion and thus investigators have considered it for use as a sole agent for treating mild hypertension. Wyeth Laboratories is conducting research with this new drug. *Clin Ther,* Vol. 4, #4, p. 275, 1981.

RAYNAUDS DISEASE:

Patients with Raynauds disease, especially if complicated by collagen disease, experience coldness in the hands which is often difficult to correct. In order to increase circulation through the extremities without resorting to systemic therapy, nitroglycerin ointment was applied to the hands. Results were compared to those obtained after lanolin application. Topical application of nitroglycerin produced beneficial results in this study and thus certain patients with Raynauds disease may experience relief without having to resort to more intense therapy. *Lancet,* Vol. 1, #8263, p. 76, 1982.

SISOMICIN:

Sisomicin is an aminoglycoside antibiotic which has been used experimentally for several years. Its activity against serious Gram negative infections was compared to that of gentamicin (Garamycin) in 101 hospitalized patients. Sisomicin produced a 93% reduction in pathogen population while gentamicin affected only 67% of the group examined. Sisomicin is being tested by the Schering Corporation. *Clin Ther,* Vol. 4, #4, p. 263, 1982.

PLASTIC STRIP THERMOMETERS:

An experiment was designed to compare a plastic strip thermometer with the conventional mercury/glass apparatus. In a group of 613 patients, the older thermometer produced more accurate readings than did the plastic strip model. Variations in ambient temperature can alter the readings taken by the newer apparatus and thus the chance for inaccuracy is increased. *J Am Med Assoc,* Vol. 247, #3, p. 321, 1982.

ARTHRITIS:

Salicylates and NSAID have long been considered the first line of therapy against arthritis, but resistant cases require more intense therapy. Patients who discontinued taking a second-line drug such as gold, penicillamine (Cuprimine) or levamisole because of toxicity were given another of these agents to see if they might be better tolerated. Follow-up studies indicate that if toxicity to one drug in the group becomes unbearable, an alternate should be tried before resorting to even more drastic therapy. *Br Med J,* Vol. 284, #6309, p. 79, 1982.

AMILORIDE-DIGOXIN INTERACTION:

Amiloride (Midamor) is a recently introduced potassium-sparing diuretic which most likely will be used in combination with a thiazide diuretic rather than by itself. Since thiazide diuretics can produce potassium depletion, the combination may be quite useful in preventing hypokalemia. This would be of special interest to patients with congestive heart failure who are receiving digoxin. Preliminary studies indicate that amiloride prevents the positive inotropic effect produced by digoxin thus reducing its value in this disease. Additionally, these investigators feel amiloride may enhance the renal secretion of digitalis glycosides. *Drug Ther,* Vol. 7, #1, p. 51, 1982.

ACYCLOVIR:

A new antiviral agent, acyclovir (Zovirax) is said to have the potential to do for antiviral therapy what penicillin did for antibacterial therapy. The drug is said to be especially useful in controlling herpes infections and the manufacturers are optimistic about its acceptance by the general medical community as the first such agent with major selectivity against the virus. *FDC Rep,* Vol. 44, #14, p. 8, 1982.

MINOCYCLINE:

Minocycline (Minocin) is unique among tetracycline derivatives in that it is more lipid soluble at physiological pH than others congeners and thus is able to penetrate tissues to a greater extent than other agents in that class. The metabolism of minocycline has been studied and it appears that thre major metabolites can be isolated. This study represents the first indepth investigation into tetracycline metabolism using a new technique which may be of value in determining the metabolites of other derivatives. *Drug Metab Dispos,* Vol. 10, 32, p. 142, 1982.

METOCLOPRAMIDE:

Patients being treated with potent emetogenic antineoplastic agents, e.g. cisplatin (Platinol) were given metoclopramide (Reglan) intravenously to reduce the incidence of nausea and vomiting associated with chemotherapy. The drug worked well without producing significant side-effects. *J Am Med Assoc,* Vol. 247, #19, p. 2683, 1982.

DIAZEPAM:

Oral contraceptives and benzodiazepine derivatives are among the two most commonly used drug groups prescribed for use in young women. Studies in women taking one or both of these drug types suggest that low dose estrogen containing oral contraceptives may interfere with the metabolism of diazepam (Valium). The interaction is of significant magnitude to strongly suggest that it be watched for in women taking both drug types. *N Engl J Med,* Vol. 306, #13, p. 791, 1982.

GINGER:

As far back as 1597, the fluid extract of the rhizome of ginger (Zingiber officinale) was used to mitigate symptoms of gastrointestinal distress. Experiments conducted in volunteers suggest that the powered rhizome of ginger was superior to dimenhydrinate (Dramamine) and placebo in protecting against motion sickness induced via artificial means. *Lancet,* Vol. 1 #8273, p. 655, 1982.

PHENYTOIN LEVELS:

Patients with epilepsy require less phenytoin to maintain plasma levels of 15 μg/ml as they age. When compared to those in the age bracket between 20 and 39 years, it was noted that a reduction in dosage amounting to 21% was required for those aged 60 to 79 years in order to prevent toxicity. *Clin Pharmacol Ther,* Vol. 31, #3, p. 301, 1982.

HEROIN:

Heroin has been used in Great Britain for analgesia associated with neoplastic disease, but its advantage over morphine is obscure. Studies conducted at Georgetown University and at the Sloan Kettering Institute indicate that although heroin is more potent than morphine milligram per milligram, its overall efficacy as an analgesic is comparable. The American Medical Association opposes legalization of heroin and this study tends to support that view. *J Am Med Assoc,* Vol. 247, #18, p. 2471, 1982.

PIRETANIDE:

A new potent diuretic, piretanide, was administered for six weeks, at times in conjunction with digoxin (Lanoxin). No variation in plasma potassium levels were noted although a potent diuretic effect was observed. Longer studies are needed to substantiate the lack of potassium depletion said to be associated with the drug. *Clin Pharmacol Ther,* Vol. 31, #3, p. 339, 1982.

CIMETIDINE:

Patients given cimetidine often experience resolution of duodenal ulcers, but no information was available to suggest what effect continued therapy might have on relapse rates. Studies using one gram of the histamine-2 antagonist daily for a time after healing has occurred indicates that there is no assurance against a relapse once the drug is discontinued. *Br Med J,* Vol. 284, #6316, p. 621, 1982.

CYCLOSPORIN A:

A new antirejection drug is thought to be superior to all other immunosuppressants available to date. Cyclosporin A produces its beneficial effects without producing the degree of toxicity associated with other agents. This year the first single lung transplant is scheduled to take place and the use of cyclosporin A figures prominently in the proposed positive outcome. *J Am Med Assoc,* Vol. 247, #17, p. 2331, 1982.

Our best friends are our severest critics and our greatest assets.

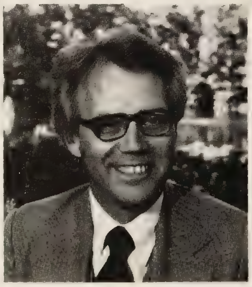
Meet our 1982 Pharmacy Consultant Panel.

H. Joseph Schutte, R.Ph
Community Pharmacist
Louisville, Kentucky

Louis M. Sesti, R.Ph
Executive Director
Michigan Pharmacists Association
Lansing, Michigan

Marilyn Slotfeldt, Pharm.D.
Clinical Services
Good Samaritan Hospital
Portland, Oregon

Donald Hoscheit, R.Ph.
Vice President, Pharmacy
Osco Drug, Inc
Oak Brook, Illinois



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Community Pharmacist
Knoxville, Tennessee

Stephen D. Roath, R.Ph
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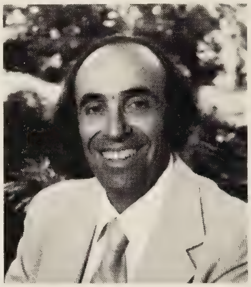
Longs Drug Stores, Inc
Walnut Creek, California



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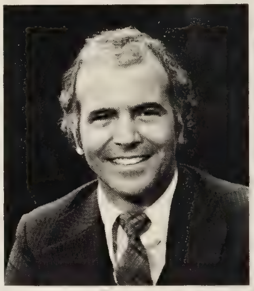
Dean, College of Pharmacy
University of Utah
Salt Lake City, Utah

Paul Burkhart, R.Ph.
Director of Pharmacy
University of Maryland Hospital
Baltimore, Maryland

Harland W. Henry, R.Ph
Director of Pharmacy
Memorial Hospital System
Houston, Texas



Lawrence A. Diaz, R.Ph.
Community Pharmacist
Gainesville, Florida

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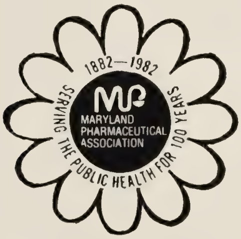
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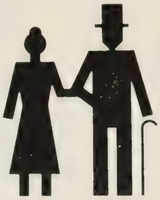

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Official Journal of
The Maryland
Pharmaceutical
Association

November, 1982
VOL. 58
NO. 11

Maintaining Financial Strength

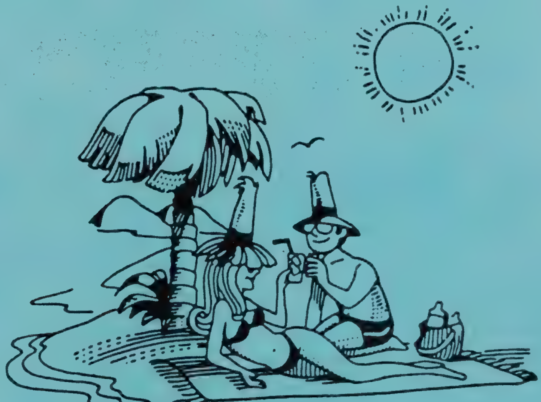
— *Bruce Seicker, Ph.D.*

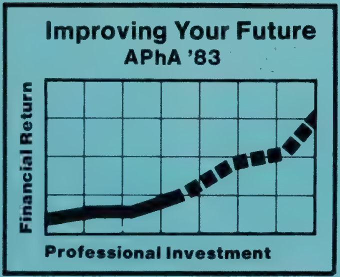
New Penalties Proposed by Board of Pharmacy

Consumer Attitudes About Pharmacists

ANTIGUA

January 23-30, 1983

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NOVEMBER 1982 VOL. 58 NO. 11

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President's Message

Presidents, Executive Directors, Members, dues. An Association is made up of none of these. It is through working together, group participation and service that an association takes character and represents what its members want it to be. It must have been this way when pharmacists came together to form this Association 100 years ago. They had the idea that forming a union of pharmacists made them stronger and better able to confront the problems of their day. Problems although different are with us today and will be tomorrow. A strong association must be supported by willing members. When I use the phrase "willing member" I mean a person who consciously realizes what this Association is trying to do for him or her. The signing of a check, the forwarding of dues should not be a perfunctory act but a realization that this money is a fee for services rendered. Services that affect all aspects of our professional lives such as continuing education, third party monitoring, legislative lobbying, peer review, impaired pharmacist aid, a working relationship with our school and etc., etc., etc. If you had to pay for these services with a flat rate or by the hour your fee might be astronomical. The fee is more than reasonable only because most of the services are accomplished with volunteer help. I used the term fee for service before but it is not even that, it is an investment in the present and the future. Try not to think that your dues check is your only connection with the Association. I know that not everyone is cut out to give hands-on help, still there are many ways to participate. Do you know that less than half of our members voted in the last election. Take some time to read *The Maryland Pharmacist* and our bulletin. Take one continuing education course. Give us some feed-back either through letters to be published in the *Pharmacist* or notes to Dave or myself. Dues are important, bodies are important, but most important is the back bone and spirit within an association that characterize its' success and worthiness.

PRESIDENT

Maintaining Financial Strength

by Bruce Siecker

The current recession has lasted so long and cut so deeply that virtually every major sector of the economy, region of the country, and type of worker has been affected. The slump—made worse by cutbacks in Medicaid spending—has hurt community pharmacies in every part of the country. Even large chain pharmacies have felt the pinch as consumer spending has softened.

Few pharmacies have well thought out financial survival plans for bad times. When trouble develops, indecision and seat-of-the-pants management prevail. As a result, too little is often done too late! Unprepared companies fail to realize the trouble they are in until a major crisis develops. Others plunge ahead on the vague assumption that things will somehow get better on their own. Tentative leadership and unfounded optimism often prove disastrous, even when a pharmacy appears to be financially healthy.

Pharmacies that survive the current recession will be those that are lucky or implement decisive actions to preserve their financial strength. Maintaining a strong financial base is the key challenge facing today's pharmacy manager. Meeting that challenge requires serious attention, tough choices, and decisive action. Those who meet the test will be poised to take full advantage of the eventual recovery.

Many factors affect how well a pharmacy does financially, and today's manager can afford to ignore none of them. But three of them demand constant vigil: *reducing costs, controlling inventory*, and *improving cash flow*.

Below are dozens of ways other pharmacies are facing the need to manage boldly and aggressively. Some may not apply to you. On the other hand, do not dismiss any of them without some forethought. Each idea provides some help; used together they can provide very powerful help to maintain a pharmacy's financial strength.

Reducing Costs

- Provide incentives to employees for ideas to reduce costs.
- Promote from within rather than hire from outside to save money and improve staff morale.
- Develop a list of ''idle time'' tasks that will make better use of existing personnel.
- Conduct inhouse training to improve employee skills. Focus on ways employees can help reduce costs and cross-training.
- Consider sub-leasing pharmacy space that is not producing adequately to a related operator.
- Ask the local utility to conduct an energy audit to reduce energy consumption.
- Defer making computer software and hardware changes unless they pay off quickly with reduced costs.
- Monitor mailing practices for opportunities to save money. Check into second and third class.
- Use white envelopes for all classes of mail; postal workers tend to handle them as first class anyway.
- Determine whether long-distance costs can be reduced by using alternate service suppliers.
- Increase security measures aimed at both internal and external theft.
- Review advertising practices with a view of highest efficiency in reaching the desired audience.
- Determine whether new equipment, which is absolutely essential, can be leased attractively to avoid major capital outlays.
- Examine payroll costs and wage rates in lieu of local conditions; consider the possibility of layoffs, reduction in wage or salary, and even permanent reductions in staff.
- Ask employees to suggest activities that can be combined or eliminated. Pay particular attention to similar and overlapping activities completed by different employees.
- Meet with key employees to get their ideas and commitments to reduce costs.
- Review insurance costs, looking for coverage that can be consolidated or reduced.
- Increase insurance deductibles to reduce premiums.
- Assign someone to look critically at the ways prescriptions are processed with the aim of reducing wasted motion and activities.
- Use high-school students for housekeeping rather than more expensive staff or a janitorial service.
- Review salary policy. Overtime merit raises and bonuses tend to become automatic.
- Eliminate unnecessary local and out-of-town travel.

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[*] By Bruce R. Siecker, Ph.D., Director, APhA Pharmacy Management Institute, 2215 Constitution Avenue, NW, Washington, DC 20037.

- For necessary travel, investigate budget motels and Super Saver rates. Use public or low-cost limo transportation services when out of town.
- Study the amount of staff time dialing the thirty most-frequently called numbers. The monthly cost of an automatic dialing device may be less.
- Get rid of all paperwork that is not essential, especially internal reports that no one reads and forms that are rarely used.
- Monitor hourly sales activity to determine whether pharmacy hours should be adjusted or staff rescheduled in response to changing sales patterns.
- Form a buying group to negotiate better terms from local suppliers.
- Decide whether you are getting your money's worth from the pharmacy's accountant, banker, legal and financial advisors.
- Talk with other pharmacy managers, and managers of related firms, to see how they are reducing costs.

Controlling Inventory

- Eliminate low-margin, slow-turnover items and lines, e.g., items with turnovers of less than three and margins of less than 30%.
- Investigate suppliers that offer consignment terms.
- Limit promotional buying to those items normally carried in stock.
- Establish a maximum time any item can be in stock before it is returned, sacrificed, or discarded, e.g., 180 days.
- Hesitate to add new lines.
- Adopt demand purchasing where the demand for the item and a target turnover determine how much is stocked.
- Reconsider direct purchase habits for their impact on increasing inventory levels because of high minimums.
- Think more about the carrying cost of inventory; carrying costs far exceed ordering costs in community pharmacies.
- Consolidate purchasing with one wholesaler in exchange for better terms and services.
- Study which lines respond best to price level; consider discounting leading items in those lines to improve inventory turnover and strengthen price image.
- Make sure the count is accurate. Check all incoming orders to be sure there are no shortages.
- Some suppliers attempt to improve their own cash flow by delivering early. Institute a "start ship" practice, especially for seasonal goods, to show the first date delivery will be accepted.
- Terminate all automatic shipment arrangements for new items.
- Stop buying every promotional deal that is offered. Deals increase inventory unnecessarily and produce a false sense of prosperity.
- Institute a program of regular physical counts. Identify high cost items, then assign someone specific responsibility to keep quantities at bare minimum.

Improving Cash Flow

- Establish a payment calendar so invoices are not paid too soon.
- Begin adding a service charge on inactive and overdue receivable accounts.
- Divide receivable accounts into two groups; bill one group every two weeks to smooth cash in-flow.
- Prepare accounts in descending dollar amounts, rather than in alphabetical or account number order.
- Mail account statements as they are completed, not waiting until they are all done.
- Use first-class postage on high-dollar accounts receivable to speed delivery.
- Establish a faster schedule for submitting third-party claims.
- Teach staff how to sell larger sizes and make companion sales, thereby increasing average sales per transaction.
- Eliminate all nonessential or low-value staff activities so they can focus more attention on customer service.
- Offer a discount for those who pay with cash.
- Have a sidewalk sale to clear out old stock, then do not restock.
- Consider offering a discount on the purchase of the second package of a given item.
- Defer nonessential capital investments.
- Partially or wholly replace cash bonuses and awards with gifts of inventory or offer employee discounts on purchases in lieu of cash awards.
- Ask your accountant whether depreciation schedules can be accelerated.
- Examine records to see whether tax deductions were missed.
- Be sure to take an investment tax credit on capital purchases. It may also be possible to get an investment tax credit on leased equipment if the lesser failed to take one.
- Take a very hard, long look at the benefits and costs of current delivery practices. Think about other ways, a reduced service level, or even elimination of delivery.
- Begin levying a delivery charge.
- Increase the charge for bad checks. Some banks are now charging $10–15 per bounced check.
- As the inventory level is reduced, adjust insurance coverage downward.
- Pay *all* bills by check; make deposits in person.
- Attempt to negotiate special, longer payment terms.
- Watch the age of receivables closely. Establish standard procedures and specific actions when account is 30, 60, and 90 days overdue.

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A Maryland Pharmacy Tradition

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MARYLAND PHARMACEUTICAL ASSOCIATION

by William J. Skinner
Chairman, Centennial Committee

Among those sterling features which sets pharmacists of Maryland apart is their network of organization, particularly in Baltimore. The Baltimore Veterans Druggists' Association is one of those "old boy" networks that has given much to the last 100 years. BVD's started in 1926 with Robert Edward Lee Williamson, Andrew Grover DuMez and Charles Chaplan Neal as officers. These gentlemen started a tradition which has stayed together since then and grown despite the demise of such groups around the United States.

The organization was originally limited to 25 pharmacists who had 25 years each in pharmacy. The monthly meetings started at the Rennert Hotel, made famous over the years by Woodrow Wilson and H. L. Mencken.

Because the organization was made up of veteran (older) pharmacists it was natural that one of the activities adopted consisted of all members attending the funerals of departed brothers. A standard ceremony was arranged and made part of the organization's procedures.

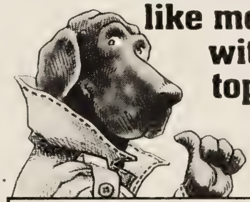
While the primary objective was to promote good fellowship among pharmacists, other activities included annual Christmas donations to many groups in the Baltimore area. In 1950 the rules of the organization were changed to permit active membership to increase to 75 and all associate members were made active.

To a man, every member of the BVDA was also active in other pharmacy organizations, such as the Alumni Association, the American Pharmaceutical Association, the National Association of Retail Druggists and local chapters of the national groups. Among the members were nonpharmacists, H. C. Byrd, the president of the University of Maryland; Joseph F. Hindes, chairman of the board of Emerson Drug Company and pharmacists who had not practiced in the community area, including Charles C. Neal, general manager of Sharp & Dohme, William C. McKenna of the Baltimore Drug Exchange and R. S. Fuqua, the chief pharmacist of the Johns Hopkins Hospital.

In 1976, 31 of the members assembled for the 50th anniversary at the Victorian Room of the apartments in Baltimore. President that year was Samuel P. Jeppi and secretary-treasurer was Dr. Benjamin F. Allen. Other recent officers have included Charles E. Spigelmire, president; Samuel A. Goldstein, 1st vice president; Alexander M. Mayer, 2nd vice president; Edward W. Piper, assistant-secretary-treasurer and Godfrey D. Kroopnick, recording secretary.

Certainly the BVDA is one of Maryland's most interesting pharmacy traditions and one that we can all be proud to see continue through the next 100 years of Maryland pharmacy.

What business does a handsome dog like me have with a top cat like you?



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The author is indebted to Dr. Charles E. Spigelmire and Dr. Stephen Provenza for information about the BVD's.

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For Your Information

New Penalties Proposed by Maryland Board of Pharmacy

.01 Scope.

These regulations establish standards for the imposition of penalties not exceeding $5,000 against any pharmacist or pharmacy permit holder in the State if, after a hearing, the Board finds that there are grounds under the Health Occupations Article, §§12-311 or 12-409, respectively Annotated Code of Maryland, to suspend or revoke a license or pharmacy permit.

.02 Definitions.

A. "Board" means the State Board of Pharmacy.

B. "License" means, unless the context requires otherwise, a license issued by the Board to practice pharmacy.

C. "Penalty" means monetary penalty.

D. "Pharmacy permit" means a permit issued by the Board to establish and operate a pharmacy.

.03 Imposition of a Penalty Generally.

After a hearing pursuant to the Health Occupations Article, §§12-312 or 12-410, Annotated Code of Maryland, the Board may impose a penalty against a pharmacist or pharmacy permit holder for violation of the Health Occupations Article, §§12-311 or 12-409, respectively:

A. Instead of, or in addition to, suspending a license or pharmacy permit, or

B. In addition to revoking a license or pharmacy permit.

.04 Imposition of Penalties on Pharmacists.

A. A penalty of not less than $100 or more than $2,000 may be imposed by the Board on a pharmacist found guilty of any of the following:

(1) Willfully makes or files a false report or record as part of practicing pharmacy;

(2) Willfully fails to file or record any report that is required by law;

(3) Willfully impedes or obstructs the filing or recording of any report that is required by law;

(4) Willfully induces another to fail to file or record any report that is required by law;

(5) Violates any provision of the Maryland Pharmacy Act, §12-510, Annotated Code of Maryland, which concerns the labeling requirements for prescription medicines;

(6) Advertises or otherwise publicly claims to prepare or fill prescriptions in a superior manner;

(7) Advertises in a manner that tends to deceive or defraud the public; or

(8) Is physically or mentally incompetent.

B. A penalty of not less than $200 nor more than $3,500 may be imposed by the Board on a pharmacist found guilty of any of the following:

(1) Provides or causes to be provided to any authorized prescriber prescription forms that bear the name, address, or other means of identification of a pharmacist or pharmacy;

(2) Splits or agrees to split fees for professional services with an authorized prescriber;

(3) Agrees with an authorized prescriber to prepare or dispense a secret formula prescription; or

(4) Accept as to an association that has remained in continuous existence since July 1, 1963, associates as a partner, co-owner, or employee of a pharmacy that is owned wholly or substantially by an authorized prescriber or group of authorized prescribers.

C. A penalty of not less than $500 nor more than $5,000 may be imposed by the Board on a pharmacist found guilty of any of the following:

(1) Fraudulently or deceptively obtains or attempts to obtain a license for the applicant or licensee or for another;

(2) Fraudulently or deceptively uses a license;

(3) Aids an unauthorized individual to practice pharmacy or to represent that the individual is a pharmacist;

(4) Is addicted to any controlled dangerous substance or habitually is intoxicated;

(5) Provides pharmaceutical services while intoxicated or under the influence of a drug with abuse potential;

(6) Without first having received a written or oral prescription for the drug from an authorized prescriber, dispenses any drug for which a prescription is required;

(7) Unless an authorized prescriber authorizes the refill in the original prescription or by oral order, refills a prescription for any drug for which a prescription is required;

(8) Violates any provision of the Health Occupations Article §12-603 of Annotated Code of Maryland, which concerns the home hemodialysis distribution

program;

(9) Is professionally incompetent;

(10) Is convicted of a crime involving moral turpitude; or

(11) Is convicted of a violation of this title or any other pharmacy law of any state.

.05 Imposition of Penalties on Pharmacy Permit Holders.

A. A penalty of not less than $100 nor more than $2,000 may be imposed by the Board on a pharmacy permit holder found guilty of any of the following:

(1) Except for a hospital pharmacy, failing to provide services to the general public or restricting or limiting pharmacy services to any group of individuals; or

(2) Offering pharmaceutical services under any term or condition that tends to interfere with or impair the free and complete exercise of professional pharmaceutical judgment or skill.

B. A penalty of not less than $200 nor more than $3,500 may be imposed by the Board on a pharmacy permit holder found guilty of any of the following:

(1) Failing to locate or equip a pharmacy so that it may be operated without endangering the public health or safety;

(2) Failing to provide complete pharmaceutical service by preparing and dispensing all prescriptions that reasonably may be expected of a pharmacist; or

(3) Making any agreement that denies a patient a free choice of pharmacists.

C. A penalty of not less than $500 nor more than $5,000 may be imposed by the Board on a pharmacy permit holder found guilty of any of the following:

(1) Conducting a pharmacy so as to endanger the public health or safety;

(2) Failing to have a pharmacy under the personal and immediate supervision of a licensed pharmacist;

(3) Failing to operate a pharmacy in compliance with the law and the rules and regulations of the Board; or

(4) Otherwise not conducting a pharmacy in accordance with the law;

D. The penalties as specified in Regulation .04 above may be imposed on pharmacy permit holders found guilty by the Board of participating in any of the activities that are grounds for Board action against a licensed pharmacist under the Health Occupations Article §12-311, Annotated Code of Maryland.

.06 Factors to be Considered in the Assessment of Penalties.

In those cases in which the Board determines that the imposition of a penalty is appropriate, the Board shall take into consideration the following factors, without limitations, in determining the amount of the penalty:

A. The extent to which the pharmacist or pharmacy permit holder derived any financial benefit from the unprofessional or improper conduct;

B. The willfullness of the unprofessional or improper conduct;

C. The extent of actual or potential public harm caused by the unprofessional or improper conduct; or

D. The cost of investigating and prosecuting the case against the pharmacist or pharmacy permit holder.

.07 Payment of Penalties.

A. Any penalty imposed under these regulations shall be due and payable to the Board as of the date the Board's order is issued unless the Board's order specifies otherwise.

B. Filing an appeal under the Administrative Procedure Act, Article 41, §255 et seq., Annotated Code of Maryland shall not stay payment of any penalty imposed by the Board pursuant to these regulations.

C. If a pharmacist or pharmacy permit holder fails to pay, in whole or in part, any penalty imposed by the Board pursuant to these regulations, the Board may not restore, reinstate, or renew a license or pharmacy permit until the penalty has been paid in full.

D. In its discretion, the Board may refer all cases of delinquent payment to the Central Collection Unit of the Department of Budget and Fiscal Planning to institute and maintain proceedings to ensure prompt payment.

E. All monies collected by the Board pursuant to these regulations shall be paid into the General Fund of the States.

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Camphor

By Lisa L. Booze, Pharmacist
Reprinted from Toxalert

Camphor is an ingredient in liniments, cold sore preparations and other products designed to be applied externally. It is still used rarely in mothballs. Accidental poisonings occur in children and frequently in adults who mistake camphorated oil for castor oil or cod liver oil. Camphor is rapidly absorbed through the skin, mucous membranes, and after ingestion. It acts primarily as a central nervous system stimulant with symptoms seen within 5-90 minutes. After ingestion, a burning sensation develops in the mouth and esophagus with nausea and vomiting also commonly seen. Stimulation can range from mild excitation to grand mal seizures. The National Clearinghouse for Poison Control Centers reports a 20% incidence of convulsions in patients with camphor intoxication. The onset of seizures may be sudden and without warning. Postconvulsive depression generally occurs and may lead to coma. Death can be a result of seizures or respiratory failure.

In children, 1 gram of camphor may be fatal and symptoms can be seen with less. Many products contain 10% or 20% camphor, therefore as little as 1 or 2 teaspoonsful can be considered a potentially lethal dose. A toxic amount of camphor in adults is 2 grams although 20 grams has been survived. There has been one case of neonatal death 30 minutes after delivery and 36 hours after maternal ingestion of camphorated oil instead of castor oil.

Treatment consists of preventing the absorption of the camphor and providing symptomatic and supportive care. Poisindex®, a major toxicology reference source, recommends lavage because of the rapid onset of symptoms. The Maryland Poison Center suggests syrup of ipecac in the asymptomatic patient and lavage if any CNS symptoms are present. Activated charcoal and a saline cathartic should follow. Oil based cathartics, alcohols, and fats (milk) are contraindicated because they promote gastrointestinal absorption of camphor. Diazepam may be needed to control seizures. Both lipid hemodialysis and resin hemoperfusion have been effective in removing camphor from the blood of severely poisoned patients. Patients should be observed by a physician for a minimum of three to four hours.

Currently, there is a campaign underway led by Carmine Varano, a New Jersey pharmacist, to remove camphorated oil from the market. The Food and Drug Administration and the Committee on Drugs of the American Academy of Pediatrics have also spoken out on the hazards and lack of benefits associated with camphor. The FDA is now in the final phase of banning this product.

APhA Publishes Seventh Edition of *Handbook of Nonprescription Drugs*

The seventh edition of the highly respected *Handbook of Nonprescription Drugs* is off the presses and proving to be a best seller for its publisher, the American Pharmaceutical Association (APhA). "Initial sales of this important text have been especially gratifying," said APhA president William S. Apple, Ph.D.

Three years in the making, the new edition of the *Handbook* has been greatly expanded over its earlier editions. Its more than 700 pages include 34 chapters, 32 of which are devoted to specific groups of drug products and the disease states for which they would be used as treatment. Each of these 32 chapters either is entirely new or has been thoroughly revised from previous editions, and each is accompanied by tables listing all major nonprescription drug products within that specific group. The individual listing include brand names, manufacturers' names, and active and (in many cases) inactive ingredients. The product information was submitted by the manufacturers earlier in 1982.

Also new in this edition are a chapter discussing the Food and Drug Administration's continuing review of nonprescription drug products, written by the director of that review, William E. Gilbertson, and a chapter on patient assessment and consultation. In addition, the new edition includes a series of color plates which illustrate common dermatologic and dental/oral disease states which are described in the *Handbook*.

The *Handbook of Nonprescription Drugs* is available for $45.00 ($30.00 for APhA members) from the Order Desk, American Pharmaceutical Association, 2215 Constitution Ave., NW, Washington, DC 20037. Orders totaling less than $200.00 and all foreign orders must be prepaid in U.S. funds; foreign orders must also include $9.00 per copy to cover shipping and handling. To obtain APhA member rate, members must attach a mailing label from an APhA periodical to their order.

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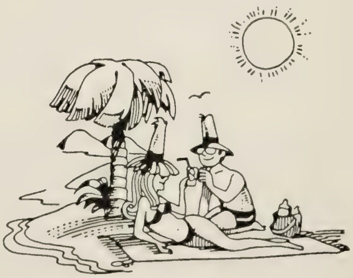

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For 15 years, pharmacists, physicians, and other health care professionals have been turning to APhA's *Handbook of Nonprescription Drugs* for valuable, practical health care information. No wonder it has earned a reputation as the most comprehensive and authoritative resource in its field—a reference you'll want to keep within arm's reach.

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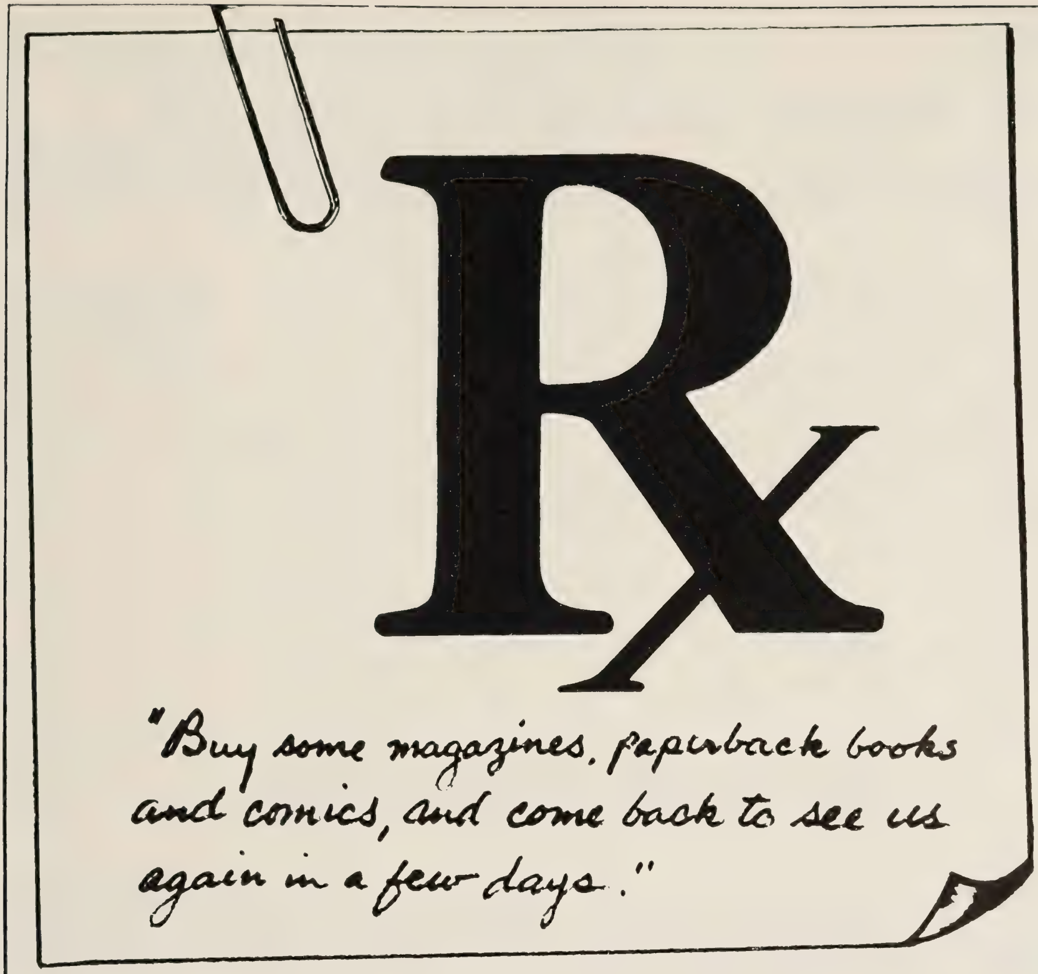
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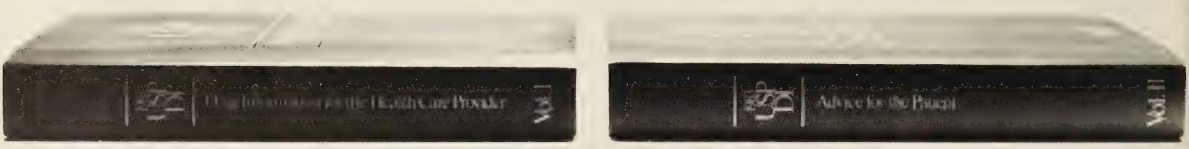

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PHARMACY NEWSLINE™

NUMBER 6

A continuing education service from WYETH LABORATORIES

EDITORS' COMMENT

"It's time to join the PAC, man!"
"Beat the heat, join PAC!"
"Political Issues? Political Action!"

What's happening in pharmacy—are we all becoming politicians? More and more, pharmacists around the country seem to be adopting the National Association of Retail Druggists' slogan of a few years ago: "Get Into Politics, or Get Out of Pharmacy!" For example:

- More than half of the state pharmacy associations have political action committees that collect contributions for candidates for local, state, and national office.
- Pharmacists have been elected to or are running for seats in the state legislatures of New Jersey, Illinois, Oklahoma, and Michigan, among others.
- Members and staff of the Kentucky Pharmacists Association recently lobbied successfully for the passage of six pieces of favorable state legislation.
- Many state pharmacy associations hold annual "legislative days" to acquaint pharmacists with their state legislators.
- More and more pharmacists attend the NARD Legislative Conference or other meetings in Washington, DC, to become better acquainted with their congressional representatives and national issues.

What's happening is that pharmacists, like many other Americans, have discovered that the political system is "where it's at." A favorable economic or professional climate does not develop by itself. The solutions to some of pharmacy's problems can be accomplished only by cultivating respect and influence in the state and national legislative arenas, and by participating in the hard work necessary to accomplish our objectives.

Do pharmacists want more professional responsibility? Favorable tax laws? Equitable third-party reimbursement? Protection against pharmacy crime? Positive results are by no means guaranteed in politics, but there's no other game in town. Gaining legislative knowledge and influence are important but, as usual, "there's no such thing as a free lunch!" The costs of legislative success are threefold: information, time and money.

Pharmacists first must be willing to obtain information—to learn about the issues important to pharmacy—and to help develop solutions to problems confronting the profession. We also must be willing to donate time to help resolve legislative issues. That means showing up at the legislature when needed, testifying on legislation, doing volunteer work for good candidates, visiting with legislators, and whatever else may be necessary. And of course, we must "put our money where our mouth is." Contributions to state and national political action committees, and to other legislative activities, are mandatory. If pharmacists aren't willing to spend money to develop active legislative programs, other interest groups are.

When was the last time you visited your state legislature? Or wrote a letter to your congressman? Or contributed to a legislative candidate or a political action committee? Do you vote in every election? The time is right, pharmacists—"Get into Politics, or Get out of Pharmacy!" The success of our nation's democratic government depends on our participation.—*RPM*

ABOUT ORGANIZATIONS

On August 26, 1932, representatives of the American Pharmaceutical Association, the American Association of Colleges of Pharmacy, and the National Association of Boards of Pharmacy, met in Toronto, Canada, to finalize the formation of an organization to ensure quality education for America's pharmacists. The resulting American Council on Pharmaceutical Education (ACPE) now is celebrating its 50th anniversary.

Although few practicing pharmacists interact directly with ACPE, its activities—accrediting professional degree programs and approving providers of continuing pharmaceutical education—benefit the entire profession. Colleges of pharmacy must meet the strict accreditation standards of ACPE every six years, demonstrating educational quality in lengthy self-study reports and during two-day, on-site visits by ACPE staff and members. The colleges realize the importance of maintaining ACPE accreditation: programs at 72 of the nation's 73 colleges of pharmacy now are accredited, and the last currently is a candidate for accreditation. ACPE's standards of accreditation are revised periodically to reflect improvements in pharmacy practice and education, and the latest revision should be completed next year. ACPE also approves providers of continuing pharmaceutical education. The more than 175 providers must meet requirements in the areas of educational quality, publicity, record-keeping, and evaluation. Many states that require continuing pharmaceutical education universally accept programs provided by ACPE-approved organizations.

ACPE is governed by a ten-member board of directors. Each of the three founding organizations appoints three members, and the tenth is appointed by the American Council on Education. The current president of the ACPE Board is Pharmacist Grover C. Bowles, Jr., of Baptist Memorial Hospital, Memphis, Tennessee. ACPE's staff, which includes Executive Director Daniel A. Nona, R.Ph., Ph.D., and Assistant Executive Director W. Robert Kenney, Ed.D., also receives direction from an advisory committee on continuing education and a public advisory panel. It is likely that ACPE's high standards of pharmacy education will be maintained in the future. Besides answering to its prestigious Board of Directors, ACPE must meet the guidelines of the US Department of Education and the American Council on Postsecondary Education. Congratulations to ACPE on a very successful 50 years!

REGULATION REVIEW

The US Court of Appeals for the Second Circuit has struck down a class action suit brought by 700 Connecticut pharmacies, ruling that Blue Cross and Blue Shield of Connecticut was the actual purchaser of prescribed drugs under its plan and that the establishment of a maximum price to pay pharmacists was not price-fixing. The pharmacists had argued that agreements between the third party and the pharmacies constituted illegal resale price maintenance or horizontal price-fixing. This is one of a growing number of cases in which the third party has been deemed the actual purchaser of prescription drugs. Such decisions essentially may negate the

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Editorial correspondence should be directed to the attention of the Executive Editor, Continuing Professional Education, Suite 800, 625 N. Michigan Ave., Chicago, IL 60611.

intended effect of the various "third-party" laws being pursued by many state pharmaceutical associations.

The Iowa Medicaid program has developed a program to provide an incentive to pharmacists to perform drug product selection when the use of generic drugs saves the program money. Effective October 1, 1982, a $0.50 reimbursement fee will be added to the $3.53 dispensing fee when generic substitution results in a savings of at least $1.50 to the Medicaid program.

As of July 1, 1982, 32 states had Medicaid outpatient dispensing fees of at least $3.00. Seven of these states had variable fees, with the highest limit of the scale above $3.00.

The states of Florida and Georgia have placed methaqualone on Schedule I, making it illegal to dispense the drug through normal delivery channels. Similar legislation has been reported in South Carolina, Louisiana, Delaware, and Alabama.

The Arizona Medicaid experiment is nearing the implementation stage. Arizona drew national notice when it adopted a Medicaid program that for the first time subjects all health care components of the program, including prescription drugs, to the bidding process. Requests for proposals are being sent out and the program could be operational by October 1st.

Responding to a request from the *Missouri Pharmaceutical Association*, the state's Attorney General ruled that a dispensing physician must perform all of the functions relating to the dispensing of medications personally, except the preparation and affixing of the label to the medication container. The Association had been concerned for some time about the dispensing of medications by unauthorized personnel and the use of improperly labeled and sealed containers.

The State of Missouri recently instituted a Medicaid client-copayment requirement that will increase pharmacists' fees to $3 on prescription medications costing $10.99 or less, and to $3.50 on medications costing more than $11.

ASSOCIATION NEWS

Massachusetts Governor Edward King was the guest of honor at a reception held at the home of Paul Dumouchel, Past President of NARD and the *Massachusetts Pharmaceutical Association.* The reception was held by the Dumouchels and many other Massachusetts pharmacists to demonstrate their gratitude to the Governor for his assistance to the profession.

The *Virginia Pharmaceutical Association* has adopted a resolution that continues and expands the efforts of an employee-employer task force established in 1981. The task force was developed to formulate VPhA programs and services for improving communications between employee pharmacists and their employers, and to develop ways of making pharmacy practice more rewarding for both groups.

The *Massachusetts State Pharmaceutical Association* recently introduced a public education program, "The Passbook to Good Health Care," via "The Brown Bag Project." In this program, senior citizens are asked to put all of their medications in a brown bag and take them to a central location. Pharmacists at the site check the contents of the bag, answer questions, and make recommendations regarding compliance, and assist in the discarding of old, unfinished, or outdated medications. Patients then are given the "Passbook," which contains a page for information on every drug the patient takes, plus other pertinent information about the patient for emergency use.

The *Missouri Pharmaceutical Association* continues its unique public service announcements using the puppet "Fred Pharmacist." Three television announcements dealing with safety closures, cleaning out the medicine cabinet, and patient compliance have been developed in addition to last year's message on the hazards of mixing medicines and alcohol. The Association also plans to make the television spots available to other state pharmaceutical associations.

Pharmacists in Colorado recently formed the *Denver Area Pharmacy Providers (DAPP)* group to compete for a contract with the Comprecare HMO to service approximately 24,000 patients. DAPP has a membership of 65 independent community pharmacies.

The *Pennsylvania Pharmaceutical Association* has commissioned a painting by artist David Armstrong entitled "The Apothecary Shop." Prints of the painting are being sold by the Association at $100 each and should become collectors' items.

A "Long Range Plan" recently was adopted by the *South Carolina Pharmaceutical Association* "to provide quality services to members in the areas of professional development, unity of purpose, and economic security, thus promoting quality pharmaceutical services to the public and enhancing the growth of the Association and the profession of pharmacy."

Pharmacists in *New Hampshire* banded together to defeat the plan of an HMO—the Matthew Thornton Health Plan—to build two inhouse pharmacies that would compete with 13 local community pharmacies. The pharmacists reminded state and federal legislators that their own tax dollars would be used to fund construction of the HMO pharmacies. The HMO agreed to rescind its plan and draw up a cooperative agreement with area pharmacies.

The *Minnesota State Pharmaceutical Association* recently published an open letter to candidates for the Minnesota legislature. The Association outlined the growth of third-party programs and difficulties the Minnesota pharmacists have had in the area of reimbursement. The letter also asked candidates to respond to the letter so that comments could be published in the Association journal for the members' information.

Members of the *Michigan Pharmacists Association* participated in the "Senior Power Day" exhibition, which attracted over 6,000 senior citizens. Members manned an MPhA exhibit booth, distributing information on drugs and the elderly and informing the public about the Association's Speaker's Bureau.

Working with law enforcement officers, security experts, former addicts and pharmacy robbers, and others, pharmacists in the Orlando area formed the *Central Florida Theft Prevention Committee.* The cooperative effort reportedly has resulted in a 90% decrease in pharmacy-related crimes in a nine-month period.

The *National Pharmaceutical Council*, recognizing that action on many health care issues will be decided on the state level in the future, will form a series of state-based health field/consumer group coalitions. The first group, the Rhode Island Medication Education Council, includes pharmacy, physician, industry, and consumer organizations. Other state coalitions will be formed and will receive support from NPC to provide information on medication and the health care system to legislators and the public.

The *Texas Pharmaceutical Association* was awarded First Prize for Interassociation Relations in a contest sponsored by the American Society of Association Executives Management Show Care for 1982. The award recognizes the Association's six-year effort to revise the pharmacy practices act in Texas through a coalition with other interest groups.

The *National Association of Boards of Pharmacy* reports that there are approximately 159,958 pharmacists in the United States. Of that number, 74.11% are involved in community pharmacy, 18.52% practice in hospital pharmacies, 1.36% are involved in manufacturing or wholesaling, 3.04% teach or are in government, and 3.02% practice in other capacities. The report also found that 20.53% (approximately 32,207) of all active pharmacists are women.

The New Jersey Academy of Consultant Pharmacists has become an official component of the *New Jersey Pharmaceutical Association.*

The *Michigan Pharmacists Association* released a study conducted by Wayne State University showing that the average Michigan pharmacy loses $10,198 annually because of inadequate reimbursement fees from third parties. The Association pointed out that pharmacists were forced to shift the expense in lost profit from over half of the prescriptions they dispensed from third-party reimbursement to the private sector.

The *Washington State Pharmaceutical Association* has redesigned its popular auxiliary drug warning labels. Thirty of the labels will use international symbols that should be better understood by the public.

The *Minnesota State Pharmaceutical Association* is offering its members a series of public service advertisements for use in newspapers. The Association will develop 26 newspaper ads so interested member pharmacies can sponsor a different ad in local newspapers every other week for a year. The ads can be customized to include the sponsoring pharmacist's picture and pharmacy name. The Association is encouraged by initial response to the ad, with more than 100 pharmacists requesting copies.

Each year, members of the *Iowa Pharmacists Association* help man a pharmacy museum at the Iowa State Fair. Volunteers serve in four-hour shifts and receive complimentary tickets to the Fair.

WHAT THEY'RE SAYING

On the Future of Pharmacy: "Exactly what do we want the pharmacy profession to become? Progress and change are necessary in any profession, but we need to take a closer look at the direction we are taking. I often wonder if the independent retail pharmacy is a thing of the past. Has pharmacy progressed so far that people will not be able to go to their neighborhood pharmacy? Will it all become impersonalized, commercialized, and computerized?

Let's get our act together. Are we willing to take a stand on issues and be held accountable for the future of our own profession? No longer can we stand in the background and let others make our decisions for us. Each and every one of us must be willing to make a commitment to our profession. We are responsible for our own actions—or lack of action.

'What can I do?' you ask, 'I am only one person.' As one person, you can become a member of your local, state, and national pharmacy organizations, attend meetings, get to know your legislators, learn the issues, voice your opinion, ask questions, use your telephone and typewriter, and involve a fellow pharmacist. All of these things, and more, will help to determine the future of pharmacy, and you can be a part of it!" *Pharmacist Marian Ricardo, Southeast Alternate Regional Director, Pennsylvania Pharmaceutical Association, in* The Pennsylvania Pharmacist, *May 1982.*

On Cooperation Between Pharmacy Colleges and Professional Associations: "Our professional associations need to be able to interact well with pharmacy's other primary resource—our colleges. Pharmaceutical association officers, executives, and members must work with faculty and students to bring out a fuller awareness of the problems, including those of an economic type, which plague pharmacy (as well as other health professions) today, because most faculty and students at many of our colleges tend to be isolated from these problems. In bringing an awareness of issues of current practitioner concern to faculty and students, pharmacy associations should strive to inculcate positive attitudes toward pharmacy practice. Problems need to be presented, but approaches to solving the problems facing the profession must also be stressed so that negative attitudes toward pharmacy practice will be avoided. Practitioner organizations should serve in an advisory way in curricular design and curricular updating at our colleges, but this must be done in a knowledgeable way, displaying an understanding of the varied and competing concerns that exist in total curricular planning, and the special needs or specialty areas of emphasis that may exist in any individual college." *Dean John L. Colaizzi, Rutgers College of Pharmacy, in "Challenges in Returning Pharmacy Practice to the Control of Pharmacists,"* The Pennsylvania Pharmacist, May 1982.

KUDOS

Congratulations to former *South Carolina Pharmaceutical Association* Executive Director J. Coleman Daniel, who recently entered the full-time ministry, and who was recently married.

Pat Powers, managing editor of the *Florida Pharmacy Journal*, and wife of Florida Pharmacy Association Executive Director Jim Powers, recently was appointed by Florida Governor Bob Graham to serve as a lay member of the Florida Board of Psychological Examiners. Congratulations!

Best wishes to *Michigan pharmacists* David Bennett and Howard Dell, who are candidates for seats in the Michigan House of Representatives.

CALENDAR OF EVENTS

October 10-14, 1982
NARD Annual Convention, Boston, MA
December 5-9, 1982
ASHP Midyear Clinical Meeting, Los Angeles, CA
April 9-15, 1983
APhA Annual Meeting, New Orleans, LA

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A Brief History of USPHS Pharmacy in Maryland

George F. Archambault

continued from the June Issue

Part XIV

There follows, to complete the article, (1) a report on the *National Clearing House for Poison Control Centers and the Pharmacist's Role* and (2) a correction to the Division of Hospitals Deputy Chief Pharmacist chronological history as appeared on page 20 of Part 1 of the article. The corrected table should be referred to from 1973 in lieu of the original—I am indebted to Pharmacist Director Kent Johnson, currently Deputy Director, Division of Drug Monographs, FDA, USPHS for this information. Johnson was chief pharmacist at the Baltimore PHS Hospital from 1970 to 1978. The Baltimore PHS Hospital along with the other PHS hospitals was phased out in early 1982 under the Reagan's economic program. It continues operation however as a non-profit local institution (Wyman Park Health Systems Inc.) and also cares for uniformed service personnel among others on a reimbursement basis from the U.S. government. Bonnie Pitt, a former commissioned pharmacist officer is currently its chief pharmacist. Pitt was the chief infectious control officer of the hospital, attached to the pharmacy department in the later years of the institution as a PHS facility. A corrected Deputy Chief Pharmacist chronological chart for the years 1973 to 1981 as supplied by Johnson follows:

DEPUTY CHIEF PHARMACIST

Walker, Thomas	1973–1974
Open	1974–1975
Walker, Thomas	1975–1977
Tonelli, Robert	1977–1978
Buehler, Gary	1978–1979
West, Robert	1979–1981

National Clearing House for Poison Control Centers—USPHS*

The poison control center concept and the first center were developed with the assistance of the previous Academy of Pediatrics in the early 1950's. The National Clearing House for Poison Control Center was established in the U.S. Public Health Service in 1957 by Surgeon General Leroy Burney to collect information on formulation and toxicity of all drugs and household products, develop treatment for ingestions, aid in the establishment of new state centers and develop educational programs to reduce childhood poisoning.

Dr. Howard Conn, Pediatrician was named Director of the new program and Pharmacist Director Henry L. Verhulst of Bethesda, Maryland, was named Assistant Director. In 1960, Dr. Conn left the Public Health Service and Pharmacist Verhulst was named Director. During the 60's and 70's Corps Pharmacists staffed the program with the responsibility of reviewing industry's material and supplying over 500 centers with toxicity and treatment information, so poisoned children could be treated efficiently.

In 1982 most activities of the program were reduced by FDA Commissioner Hayes "because of its success in achieving its goals, future activities will be concentrated on collecting information about poisonings, analysing that information and communicating any significant problems that are uncovered."

The deaths to children under 6 years of age from poisoning from liquid and solids dropped from about 450 in 1960 to about 110 in the late 1970's. Hopefully we will not see a reversal of this trend.

Conclusion

A reading of this short history of PHS pharmacy and pharmacists in and of Maryland is by its very nature an incomplete one. Apologies are made for names inadvertently omitted and duty stations not remembered. Readers are invited to add to this report by letters to the editor of this Journal for publication in later issues to help complete "the record."

---

* As reported to the author by Pharmacist Director (Retired) Henry L. Verhulst of Bethesda, Maryland—1982.

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LETTERS

Dear Mr. Banta:

I very much appreciate the old prescription and apothecary jar which you so thoughtfully presented to me on September 28, 1982. I was pleased to proclaim "Maryland Pharmaceutical Association Founding Day" and am glad that you were able to join me for the proclamation ceremony.

You have my best wishes.

Sincerely,
Harry Hughes
Governor

Dear David,

Colorado Pharmacal Assn. would like to extend heartiest congratulations to you and your fine organization on your one-hundredth anniversary October 1882-1982.

Pharmacy has come a long way since then and many of these changes must be attributed to the Maryland association and the thousands who have labored zealously in the pursuit of better health care for all.

As you start a new century of benefit to mankind through pharmaceutical education may you continue to grow and prosper as you have in the past.

Best wishes to all.

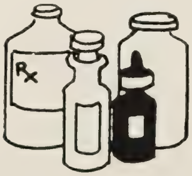
Sincere regards,
Arthur C. Hassan, Jr.
Executive Director, CPhA

Gentlemen:

Does anyone remember a Medicated Ointment called "ROSE-VEL" which was made by H. Clarke and Sons, Inc. in Riverdale, Maryland? They are now out of business and several years ago, I obtained this ointment from a firm on Roade Island Ave. N.E. I believe. Food and Drug has no information on this product.

Can anyone help me to locate this Boric Acid base, of Petrolatum and Paraffine Medicated Ointment?

Thank you,
Ernest Zsoldos
3513 Parkway Terr. Drive, #2
Suitland, Maryland 20746
Phone: 736 0165 or 735 2420



Dear Mr. Dave Banta:

I would like to take this opportunity on behalf of Charles R. Buck, Jr., Sc.D., Secretary of Health and Mental Hygiene, to thank the Association for having provided the necessary funds to keep the Division of Drug Control newsletter in circulation. Without your cooperation, the Department would not have been in a position, due to budgetary restraints, to continue to develop and apprise appropriate professionals of such meaningful data.

Please be advised that the Division has been adequately funded for the 1983 fiscal year, therefore, will be mailing the newsletter as in the past.

Again, we truly appreciate your assistance and look forward to many years of cooperative efforts.

Sincerely yours,
Charles H. Tregoe, Chief
DIVISION OF DRUG CONTROL

Dear Mr. Banta:

Enclosed please find the Centers for Disease Control (CDC) Revised Recommendations on Retesting with Tubersol (5TU Tuberculin Antigen by Connaught).

To summarize their recommendations:

1) Retest with Tubersol those individuals on Isoniazid (INH) preventive therapy based on positive reactions to "Old Batch" Aplisol.
2) *Retesting is not recommended*
    a. Close Contacts
    b. Abnormal Chest X-Rays
    c. Tuberculosis Cases
    d. Foreign Born
    e. Indurations Greater than 20 mm
    f. Negative Skin Test.

Please disseminate this information to members of your organization. Thank you for your assistance.

Sincerely,
Stanley A. Morita, Chief,
Respiratory Disease Control Program
(301) 383-2816

Consumer Attitudes about Pharmacists

A recent study exploring the reasons consumers select a particular pharmacy reveals that the choice is firmly based on personal as well as professional criteria. In examining pharmacist-consumer views on key issues, the independent study, commissioned by the Schering Division of Schering-Plough Corporation, reaffirms data collected four years ago.

"Once again, a pharmacist's advice and counsel on health matters, fast prescription service and helpful, courteous sales-people were among the factors cited most often by consumers," according to G. F. Tom Grimaldi, vice president—industry affairs, Schering Division. "The findings confirm the growing recognition of the pharmacist as a health professional concerned with the well-being of his customers," he said.

The study, Schering Report IV, followed up on a 1978 Schering Report, which probed the significant differences between pharmacist and consumer points of view on a wide range of issues. Results were developed from over 200 personal interviews with pharmacy owners, managers and employees of both chain and independent pharmacies in 20 metropolitan areas. Consumers surveyed included a national sampling of 2,000 men and women.

"Overall, there is ever-growing evidence of consumer satisfaction with their pharmacists," Grimaldi noted. "In the earlier survey, 56 percent of consumers reported that pharmacists filled their prescriptions promptly. In the new study, that figure rose to 73 percent, a significant improvement in an important aspect of pharmacy."

"On the other hand," he continued, "some 22 percent of consumers were annoyed because their pharmacy took too long to fill prescriptions. Nevertheless, nearly half of the consumers have no serious complaints about their pharmacy."

On the question of the pharmacist as a professional, with number one representing "health professional" and number seven "skilled worker", the consumer's rating increased from 3.2 percent in 1978 to 2.9 percent in the new study.

Of the 15 factors considered in a consumer's selection of a pharmacy, pharmacists and consumers strongly agree that the pharmacist would detect prescription errors and tell the patient about the prescription even when the patient doesn't ask. They also agree that the consumer's confidence in the pharmacist's recommendation of nonprescription medicines is an important factor.

But some differences in perceptions and expectations do exist. "Interestingly enough, three primary areas of disagreement involve the pharmacist's availability for consultation," Grimaldi pointed out. "Pharmacists rank these statements in first, second and third place as reasons consumers patronize a particular pharmacy: pharmacist is available to ask about medications; pharmacist is available to ask about health problems; and it's easy to get the pharmacist to talk. Consumers, however, listed these factors in seventh, twelfth and eighth positions."

The consumer's top three reasons for selecting a drugstore were: pharmacist fills prescriptions promptly; complete confidence in my pharmacy; and it's easy to talk to my pharmacist. Pharmacists, on the other hand, ranked these factors in fifth, seventh and eighth order.

Differences in perception also emerged on the issue of helpful, courteous nonpharmacist salespeople. This was the third most important factor in a consumer's choice of a pharmacy. Pharmacists placed this reason in ninth place. "This suggests that pharmacists train their nonpharmacist salespeople to be more attentive to the consumer's personal needs," he said.

Another major finding surfaced when consumers were asked to complete the statement: "the one thing I like best about the pharmacy I usually go to is. . . ." Some 31 percent said they like *the* pharmacist best. "His professionalism was singled out by 15 percent of the consumers in the 1978 study compared to 22 percent in the new report," Grimaldi noted. "Friendliness also scored high in both studies."

"Consumers also like a convenient location, fair prices and overall good service," he added.

Finishing the statement "the thing that annoys me most about the pharmacist I usually go to is . . .", nearly half of the consumers said nothing annoyed them. The most frequent complaint was slow prescription service, a crowded and cluttered store and having to wait in line to pay for a purchase. Annoyance over the perceived high price of drugs actually fell from nine percent in 1978 to eight percent in 1982.

Summarizing the survey results, Grimaldi stressed the importance of personal factors in pharmacist-consumer relations. "While consumers are quite satisfied with their pharmacists, there is still room for gaining greater consumer confidence, improving services and increasing sales," he said. "Pharmacists should make themselves more available for consultation on health matters, try to fill prescriptions promptly or at least explain why the delay is necessary, and institute training programs for salespeople and new pharmacists. Taking these steps, pharmacists can better serve the community while enhancing their professional status."

A booklet summarizing the Schering study is available by writing: Pharmacy Affairs, Schering Division, Kenilworth, New Jersey 07033.

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Dictionary of Drug Names

The new, fully cumulative 1983 edition of *USAN and the USP Dictionary of Drug Names* has been published by the United States Pharmacopeial Convention. This 20th Anniversary edition of the dictionary has 709 pages and a trim size of 8-¼″ × 11″ and it lists more than 18,000 entries, exclusive of cross-references and the appendixes. All U.S. Adopted Names (USAN) released from June 15, 1961, when the USAN program began, through June 15, 1982, are included.

USAN are adopted by the U.S. Adopted Names Council, which is co-sponsored by the American Medical Association, the American Pharmaceutical Association, and the Pharmacopeial Convention, with participation also by the U.S. Food and Drug Administration.

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For the first time, all international nonproprietary names (INN) published by the WHO from the start of the INN program in 1953, through 1981 are included; 4197 INN are thus represented. As a complement to the policy of covering all INN, more than 2300 graphic formulas relating to INN are included in *USAN 1983*. No other publication is known that provides this entire body of information on INN in one book. This feature is viewed as enhancing the usefulness of *USAN and the USP Dictionary of Drug Names* to both domestic and international subscribers.

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In addition to the 2104 USAN and the 4197 INN, the book includes more than 5100 brand names of research-oriented firms; 2650 investigational drug code designations; official names of USP XX and NF XV articles with their chemical names and graphic formulas; and other names for drugs, both current and retrospective.

The main alphabetic section of the book is followed by lists of CAS (Chemical Abstracts Service) registry numbers and NSC (National Cancer Institute) numbers. The USAN and USP and NF names are cross-indexed by pharmacologic-therapeutic categories. Three appendixes cover Guiding Principles for Coining U.S. Adopted Names for Drugs; Molecular Formulas and Corresponding USAN or Other Names; and Names and Addresses of Domestic Firms Concerned with Compounds for Which USAN Have Been Selected.

Orders for the new edition of *USAN/USP-DDN* should be addressed to the USAN Division, USP Convention, Inc., 12601 Twinbrook Parkway, Rockville, MD 20852. The price is $35.00 per copy, with quantity discounts for eleven or more copies.

Pharmacists Prescribe Appropriately Study Shows

In the first study to emerge from a five-year California pilot project permitting drug prescribing by pharmacists, a team of California researchers report in the September *American Journal of Hospital Pharmacy* that pharmacists prescribed drugs for psychiatric inpatients as safely and appropriately as physicians.

A panel of four clinical judges independently evaluated the appropriateness of drug prescribing of three certified pharmacist prescribers and two psychiatrists over a one-year period at a 40-bed mental health facility in California, according to Glen L. Stimmel, Pharm.D., of the University of Southern California School of Pharmacy, and his associates.

The pharmacist prescribers were assigned diagnosed psychiatric inpatients whose treatment plan was primarily pharmacologic. For each prescriber, 60 prescriptions were randomly selected to include 20 neuroleptic drugs, 20 anticholinergic drugs (used to alleviate the Parkinson-like syndrome induced by neuroleptic drugs), and 20 antidepressant drugs.

A prescription evaluation form was designed to access the quality of prescribing for six variables. Four expert clinical judges, who were not associated with the project or the mental health center, individually evaluated each prescription based on American Psychiatric Association criteria.

When scores for all three drug classes were combined, one scale showed no difference while pharmacists' scores were better on five of six scales and when all six scales were combined.

The study shows that pharmacist prescribers actually outperformed physicians in appropriately prescribing certain classes of drugs. Since the scores for all prescribers in most areas were in the appropriate range, the authors emphasize that it is not possible to claim clinically important differences among the prescribers.

The investigators conclude that pharmacists' prescription orders for psychiatric inpatients were as appropriate as physicians' orders.

The authors recognize that several limitations in the design and execution of the study should be considered. While these findings cannot be extended to all pharmacists, this report supports earlier studies of clinical pharmacy services in skilled nursing facilities and other institutional settings that indicate that a substantial amount of patient care can be provided by clinical pharmacists in cooperation with physicians.

The *American Journal of Hospital Pharmacy* is the official monthly publication of the American Society of Hospital Pharmacists.

HYATT
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Dr. David Roffman participated in the October 3rd Continuing Education Coordinating Council Program on Cardiovascular Drugs which was held at the new Baltimore Hyatt Regency Hotel.

Over 100 Pharmacists attended this first CECC program of the new season. It was designated the Henry Seidman Memorial Lecture.

The Frederick County Pharmaceutical Association met recently and installed its new officers. They are; Jim Rutten, President; Mary Green, President-elect; Don Ceccorulli, 1st Vice President; Mel Sollod, 2nd Vice President; Dan Mackley, Secretary-Treasurer.

The Basement of the Kelly Building has been the site of several Pharmacy related parties, fraternity rushes and social gatherings as the School of Pharmacy begins the new school year.

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ABSTRACTS

Excerpted from PHARMACEUTICAL TRENDS, published by the St. Louis College of Pharmacy; Byron A. Barnes, Ph.D., Editor and Leonard L. Naeger, Ph.D., Associate Editor

TRIENTINE:

Patients with Wilson's disease are usually treated with penicillamine (Cuprimine) to chelate copper in their plasma and thus control the development or exacerbation of symptoms of copper toxicity. Approximately 10% of the patients treated with this drug will develop a form of immunological intolerance to the agent and demonstrate symptoms which may include lupus, hemolytic anemia and/or nephritis. Trientine is a new chelating agent which has been used successfully to treat patients who were unable to tolerate penicillamine therapy. *Lancet,* Vol. I, #8273, p. 643, 1982.

CHOLESTEROL:

A synthetic peptide has been used to act as a detergent to dissolve lipids and activate the letithin-cholesterol acyltransferase enzyme system which is necessary for the mobilization of body cholesterol. The peptide (LAP-20) contains 20 amino acids and has been used successfully in animal experiments. The drug will be studied in man to see if it might have toxic and/or antigenic action before extensive testing can be continued. *J Am Med Assoc,* Vol. 247, #11, p. 1539, 1982.

ESSENTIAL HYPERTENSION:

Captopril (Capoten) was administered to hypertensive patients and responses were monitored. Patients who did not adequately respond to this therapy were given either a beta adrenergic blocking agent or a thiazide diuretic. The effect of the beta-adrenergic blocking agent was minimal as expected, suggesting that the hypertension was unrelated to renin release or angiotensin II excess. Thiazide diuretics are more effective in patients who respond only minimally to captopril therapy. *Br Med J,* Vol. 284, #6317, p. 693, 1982.

IRON CHELATION:

Desferrioxamine B (Desferal) is used to reduce the plasma concentration of iron in cases of toxicity. Several agents, derivatives of pyridoxal, have been found to have value in these situations. Initial studies indicate that the new drugs may be more effective than desferrioxamine in removing excessive iron from the body. *Pharmacol Exp Ther,* Vol. 221, #2, p. 399, 1982.

LEPROSY:

The therapy for leprosy varies in different locations. A new regimen has been developed which has been proven to be as effective as most currently used programs, but is not as expensive. Rifampin is used in a single monthly dose of 1200 mg and dapsone is used on a daily basis. If necessary, clofazimine may be added to increase the likelihood of remission. *Lancet,* Vol. 1, #8283, p. 1199, 1982.

VALPROIC ACID:

Since aspirin displaces phenytoin (Dilantin) from binding sites on plasma proteins, it was of interest to see if the same effect was present when aspirin was administered to patients receiving long-term valproic acid (Depekene) therapy. Studies conducted in children indicate that aspirin will not only displace the anticonvulsant from its binding site on plasma protein, but it also may interfere with its metabolism. Patients using valproic acid for long periods might show signs of toxicity if aspirin is ingested. *Lancet,* Vol. I, #8283. p. 1199, 1982.

DIAZEPAM:

Chlordiazepoxide (Librium) has been used to reduce the discomfort associated with alcohol withdrawal, so studies were designed to test the effectiveness of diazepam (Valium) in this situation. Animal studies indicate diazepam is a safe alternate to chlordiazepoxide in suppressing signs of alcohol withdrawal. *J Pharmacol Exp Ther,* Vol. 221, #2, p. 319, 1982.

AZATHIOPRINE:

Chronic ulcerative colitis may be unresponsive to various therapeutic regimens. This has prompted investigators to use azathioprine (Imuran) in a double-blind study to see if it might be of value in this condition. Although nausea was commonly seen as a side-effect, the researchers felt that the efficacy of the drug has now been established and that it be considered for use in patients who are refractory to normal therapy and for whom surgical treatment is inappropriate. *Br Med J,* Vol, 284, #6325, p. 1291, 1982.

MALARIA:

Patients exhibiting symptoms of malaria were examined and found not to have the malarial parasite present in their blood cells. Normally this would exclude the possibility of the disease, but further studies found the condition to exist. The patients in question were surveyed and were found to have taken cotrimoxazole (Bactrim, Septra) prior to admission. Trimethoprim, a component of the combination, was originally used as an antimalarial and apparently complicated the diagnosis by removing the parasite, but not completely eradicating the condition. Patients with symptoms of malaria and a history of cotrimoxazole therapy should be considered as having malaria until additional tests indicate otherwise. *Br Med J,* Vol. 284, #6239, p. 1616, 1982.

QUINIDINE-DIGOXIN INTERACTION:

Most of the digoxin (Lanoxin) administered is found to be excreted in the urine unchanged. Concomitant administration of quinidine increases digoxin levels via several postulated mechanisms, including displacement of the glycoside from tissue binding sites, decreased vascular volume, and reduced renal clearance. Investigators now postulate another possible mechanism. They suggest that quinidine may interfere with the extra-renal secretion of digoxin in the gastrointestinal tract. *J Pharm Pharmacol,* Vol. 34, #4, p. 280, 1982.

RECOMBINANT LEUCOCYTE A INTERFERON:

Interferon has been prepared for human use via biosynthetic techniques. Studies conducted in 16 patients show almost half of the patients experienced objective evidence of tumor regression while receiving the hormone. Side-effects included chills, myalgias, headache, fatigue, and reversible leucopenia and granulocytopenia. *Ann Intern Med,* Vol. 96, #5, p. 549, 1982.

RESPIRATORY RATES IN ELDERLY:

Measurement of respiratory rates in elderly patients may be useful as an indicator of lower respiratory infections. Normal rates of 16 to 25 respirations per minute were found to be associated with all types of infections, but elevated respiratory rates were found to proceed clinical signs when a lower respiratory tract infection was present. Determining respiratory rates in the elderly may be a valuable and simple method of predicting the presence of a lower respiratory tract infection. *Br Med J,* Vol. 284, #6316, p. 626, 1982.

DIFLUNISAL:

Diflunisal is a salicylate derivative which was discovered while searching for a more effective and less toxic salicylate. The drug is said to be more effective than aspirin and has a longer plasma half-life. MSD is marketing the drug under the name of Dolobid. *J Clin Pharmacol,* Vol. 22, #2, p. 89, 1982.

NAPA:

Procainamide (Pronestyl) is metabolized to an active antiarrhythmic agent, n-acetyl procainamide (NAPA). This metabolite does not accumulate in therapeutic concentrations if renal function is normal, but it may be found in excessive amounts in those patients experiencing renal impairment. When using evaluative techniques to measure the amount of the antiarrhythmic agent in patients with renal problems, one must be aware of the presence of this metabolite and adjust the dose of the parent compound to account for its presence. *Clin Pharmacokinet,* Vol. 7, #3, p. 206, 1982.

ANTIDEPRESSANT THERAPY:L

Patients with pre-existing chronic heart disease are often not considered for tricyclic antidepressant therapy because of the cardiovascular toxicity associated with the use of these agents. Studies indicate that tricyclic antidepressants can be used safely in patients with cardiac dysfunction as long as the impairment is not severe. They feel much of the concern over the use of these drugs in patients with cardiovascular problems has resulted from problems which have occurred when the medication was taken in overdoses. *N Engl J Med,* Vol. 306, #16, p. 954, 1982.

CAFFEINE:

Birth defects may be caused by a large variety of substances. Caffeine is a drug frequently ingested during pregnancy so its effect on fetal development was studied. No correlation between caffeine ingestion and teratogenic effects was noted. *J Am Med Assoc,* Vol. 247, #10, p. 1429, 1982.

CEFTAZIDIME:

Another cephalosporin derivative has been synthesized which has been found to be active against Pseudomonas in immunocompromised patients. It gained access to pus, sputum, and bile in sufficient concentrations to produce a therapeutic effect. Much work is being done in an effort to find an alternative to aminoglycoside therapy for the treatment of Pseudomonas aeruginosa. *Lancet,* Vol I, #8282, p. 1152, 1982.

WOMEN ATHLETES:

Women who participate regularly in long distance running events may experience a decrease or cessation in menstruation. While studying a group of amenorrheic women, it was noted that premature bone loss may be associated with this condition. Women athletes have little fatty tissue and a low level of estrone. Estrone is synthesized from the adrenal hormone androstenedione in the fatty tissue and since fatty tissue is lacking, estrone synthesis is diminished. Decreased estrogen concentrations are thought to play some rule in osteoporosis associated with the post menopausal state and so prospective studies are being conducted to determine if bone density decreases in women athletes. *J Am Med Assoc,* Vol. 248, #5, p. 513, 1982.

CIMETIDINE AND ANTACIDS:

Antacid therapy is sometimes used in conjunction with cimetidine (Tagamet) administration in efforts to reduce discomfort associated with ulcer disease. Studies conducted in Washington, D.C. indicate that most commonly used antacids will inhibit the absorption of the H-2 antagonist and thus reduce its efficacy. The authors of this article suggest that cimetidine not be given concomitantly with an antacid, that antacids may be given one hour before or after cimetidine administration in the fasting state or one hour after the drug is given in the fed state. *N Engl J Med,* Vol. 307, #5, p. 400, 1982.

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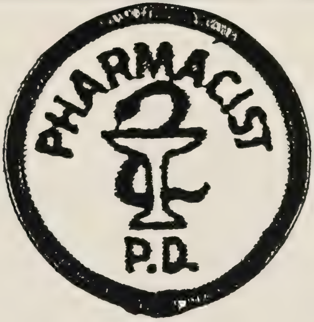

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November 14—"Diabetes" Columbia Hilton, CECC Program

November 14—Alumni Association Dinner Meeting

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March 27—"Arthritis" Ramada Inn, Baltimore, CECC Program

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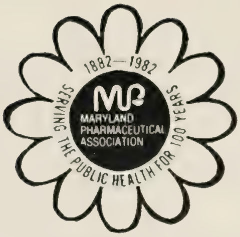
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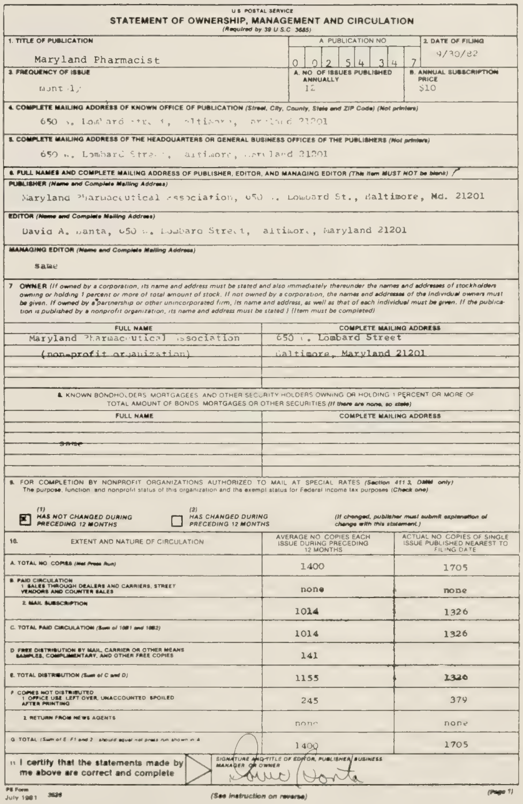

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1882-1982

**Official List of Members
During the Centennial Year**

THE MARYLAND PHARMACIST

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President's Message

Remember the story of the shepherd, his neighbors and a wolf and how he cried "wolf" once too often. A good parable but I seem to remember another that I read somewhere.

Visualize a peaceful land many many years ago; endowed with all the things a people would want, a chance to work, a chance to make a good living and a chance to raise a family. This land was called Pharmacopia. The inhabitants being called Pharmers worked 10–12 hours a day and so prospered, bringing each family peace, self respect and good fortune. The Pharmers were a close-knit society helping each other when circumstances dictated and everyone knew everyone else. Descendent followed descendent and things generally went well except for occasional marauding packs of wolves that attacked the sheep and cattle. Then the Pharmers would band together and repel these attacks and life would go on again. But as years followed years something gradually was lost to these people. They became self-satisfied, complacent and thought so much more of their creature comforts. Some started decorating and enlarging their carts as symbols of stature while others added more oxen to give them more horsepower. A few went so far as digging large holes behind their huts and filling them with water to give relief during the hot summers. Not many relished the gruelling work and long hours of dedication needed to hold on to what their fathers had enjoyed. Pharmer no longer knew Pharmer and so fewer banded together to fight the marauding wolves. Most thought, "why fight?" The wolves only take a few sheep, we still have enough. It did not seem worth the effort. As most of you can imagine the good life started to disappear, the wolves became many and the will to resist dwindled. The Pharmers gathered together no more but remained on the farms preserving what remained of a good and honorable occupation until everything was devoured.

I understand that discovered in the hut of the old wise man who told this story was written an epitaph on the wall: "qualis vita, finis ita"—Translated freely—As you spend your life, so the end will be.

PRESIDENT

USP Tips on Detecting Tampering

The recent deaths from the deliberate introduction of cyanide into a medicine have made us all aware that no matter how good a program of drug testing, regulation, and protective packaging may be devised, total security cannot be provided against all of the possibilities that sick minds may invent to tamper with our medicines or other consumer goods.

Although new protective packaging requirements doubtless will be developed, the following information is offered to help detect any possible tampering with over-the-counter (OTC) medicines.

Protecting Yourself

The first step in protecting yourself is an awareness that tampering, although probably very rare, may occur. Then it's up to you to apply some common sense. Here are some general suggestions.

- Take a few seconds to visually inspect the outer packaging of the drug product before you buy it and again as you first open it at home.
- Don't take medicines that show even the slightest evidence of tampering or don't seem "right".
- Never take medicines in the dark or in poor lighting. Look at the label and the medicine *every time* you take a dose.
- When selecting a drug product consider, among other factors, how it is packaged. If the medicine has a protective packaging feature, it should be intact. Some examples of packaging which may help deter tampering include:

Package Type	**Description**
Film wrappers	Film wrapped and sealed around the drug dosage form and/or its container.
Blister/strip packs	Individually sealed dosage units.
Bubble packs	Product and container sealed in plastic, usually mounted on/in a display card.
Shrink seals/bands	Bands or wrappers which fit tightly around cap and container.
Foil, paper, or plastic pouches	Sealed individual packets.
Bottle seals	Paper or foil sealed to bottle mouth under cap.
Tape seals	Paper or foil sealed over carton flap(s) or bottle.
Breakable caps	Plastic or metal caps, parts of which must be broken to remove.

Checking Your Medicines—Here are some tips

Packages

- Are there bits of paper or glue on the rim of the container, indicating there once had been a bottle seal?
- Does the cotton plug or filler in a bottle appear to have been removed and put back?
- Are there breaks, cracks, or holes in the outer wrapping or protective cover or seal?
- Does the outer covering appear to have been disturbed, unwrapped, or replaced?
- Is the bottle over-filled or under-filled?
- Does a plastic or other shrink band around the top of a bottle appear distorted or stretched, as though it had been rolled down and then put back into place? Is the seal missing? Has the band been slit and retaped?
- Is the cap on an unsealed container tight?
- Are the instructions wrinkled, misplaced, or missing?
- Is the information and the lot number on the container the same as that on its outer wrapping or box?

Liquids

- Is it the usual color and viscosity?
- Liquids should not have particles in the bottom of the bottle or floating in the solution.
- Normally clear liquids should not be cloudy.
- Does it have a strange or different odor (for example, bleach, acid, gasoline-like, or other pungent or sharp odor)?
- All eye drops are required to be sealed at time of manufacture to protect their sterility and indicate evidence of any opening.

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Tablets

- Has their appearance changed: Is the color different? Do they have unusual spots? If they normally are shiny and smooth, are some dull or rough?
- Do the tablets have a strange or different odor or taste?
- Are the tablets moist rather than dry?
- Are the tablets all the same size and thickness?
- If imprinted, do all tablets have the same imprint? Is the imprint missing from some?

Capsules

- Are they cracked or dented?
- Do they have their normal shiny appearance or are some dull or have fingerprints on them as though they have been handled?
- If imprinted, do they all have the same imprint? Is the imprint missing from some?
- Are they of uniform size and color?
- Do the capsule contents appear to be equally filled? Are the capsules all the same length?
- Do they have an unexpected or unusual odor?

Tubes and Jars (Ointments, creams, pastes, etc.)

- Check the bottom as well as the top of a tube, especially if it is a metal tube crimped at the bottom like a toothpaste tube. It should be firmly sealed.
- Are ointments and creams smooth and non-gritty? Have they separated?

Keep in mind that not every change in the appearance or in the condition of a product means that the package has been tampered with. The manufacturer may have changed the color or the packaging of a medicine or the product may be experiencing deterioration or may have experienced rough or unusual handling in shipping. Also, some minor product variations may be normal.

Whenever you suspect anything to be out of the ordinary or unusual about a medicine or its packaging, have your pharmacist look at it. Pharmacists know what the usual appearance of the packaging and the product should be. If there are genuine problems with a drug product or a medical device, your pharmacist may report it to the Drug Product Problem Reporting Program (DPPR), which is coordinated by USP and funded by FDA, with the cooperation of the American Society of Hospital Pharmacists and state pharmacy associations.

ACA RELEASES MINI-BOOKLETS FOR COMMUNITY PHARMACY MANAGEMENT

The American College of apothecaries announces the completion of four mini-booklets, written to assist community pharmacy practitioners to manage the community pharmacy. Two additional booklets are planned and will be released in the near future.

The four booklets presently available are:

- *Guidelines For Prescription Pricing*
- *Guidelines For Locating a Pharmacy Practice*
- *Guidelines For Financial Planning*
- *Guidelines For Inventory Control*

For more information contact:

The American College of Apothecaries
Publications Director
874 Union Avenue
Memphis, Tennessee 38163
(901) 528-6037

Smoking Clinic Available

For those smokers interested in quitting, the American Lung Association of Maryland offers a FREEDOM FROM SMOKING Clinic as well as a self-help program. Both programs have been thoroughly researched and tested.

The FREEDOM FROM SMOKING Clinic, taught by a trained volunteer facilitator, consists of an orientation and seven two-hour sessions. Behavior modification and group support techniques are used to help the smoker make the transition to becoming a nonsmoker. The $25 fee provides for handouts, a comprehensive maintenance manual and a relaxation cassette tape. Arrangements can be made to hold the clinic in a business or community setting.

The FREEDOM FROM SMOKING self-help program, designed to help smokers quit on their own, consists of two manuals, a step-by-step quitters manual called, "Freedom From Smoking In 20 Days" and a maintenance program for the new ex-smoker, known as "A Lifetime Of Freedom From Smoking". Behavior modification and self-monitoring techniques are the basis for the self-help program. The fee for the self-help manuals is $7.00.

For information about our stop-smoking programs contact the American Lung Association of Maryland at 685-6484 or 1-800-492-7527.

We care about every breath you take.

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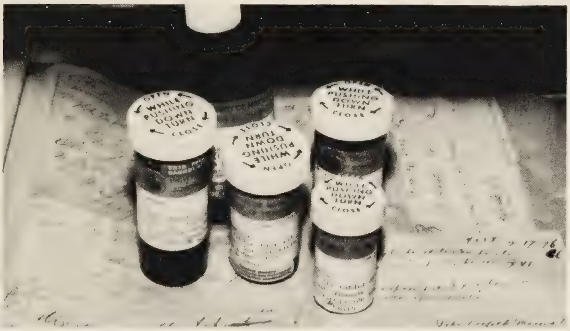

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Governor Harry Hughes declared October 5, 1982 to be the Pharmacy Association Founding Day in Maryland. Shown here with the Proclomation are: (left to right) Executive Director David Banta, Vice President William Hill, Governor Hughes, President Milton Sappe, and Chairman of the Board Philip Cogan. Sappe presented the Governor with a Centennial Apothecary Jar and some antique prescriptions.

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Dr. Arthur S. Flemming, president of the National Council on Aging and former secretary of Health, Education and Welfare under Presidents Eisenhower and Kennedy, has been named advisory board chairman of The Center for the Study of Pharmacy and Therapeutics in the Elderly established recently by the School of Pharmacy of the University of Maryland at Baltimore. Shown here at the time of the announcement are: (left to right) Chancellor Albert Farmer, Arthur S. Flemming, Dean William Kinnard Jr., and Center Director Peter P. Lamy.

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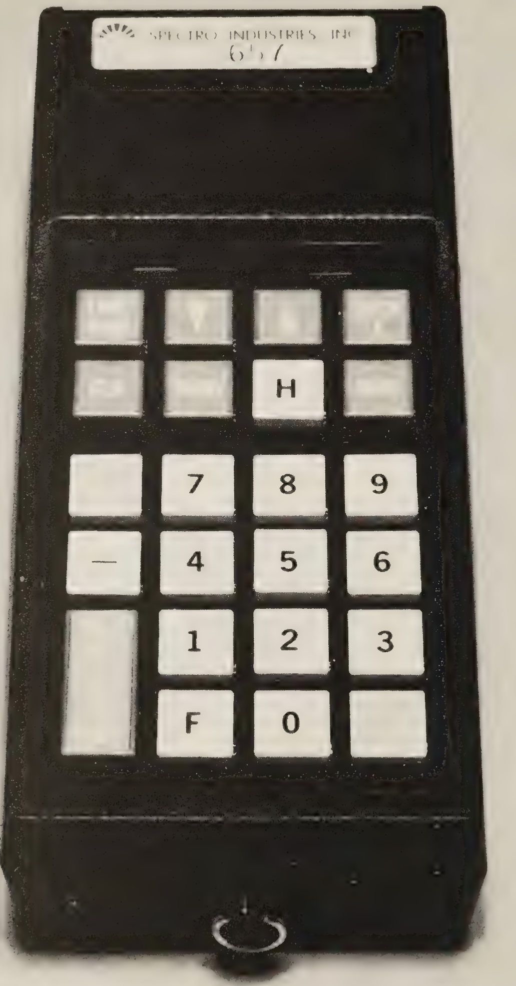

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Last summer, four young people joined The Upjohn Company as part of the NPC Pharmacy Internship Program.

They added to their educational process.... learned about manufacturing, quality control, pharmaceutical research, and marketing/sales.

We hope we answered their questions. Certainly, we took their suggestions to heart.

And when the 10 weeks were over, we parted knowing that we'll enjoy seeing each other in the years ahead.

And reminiscing about the summer of '82.

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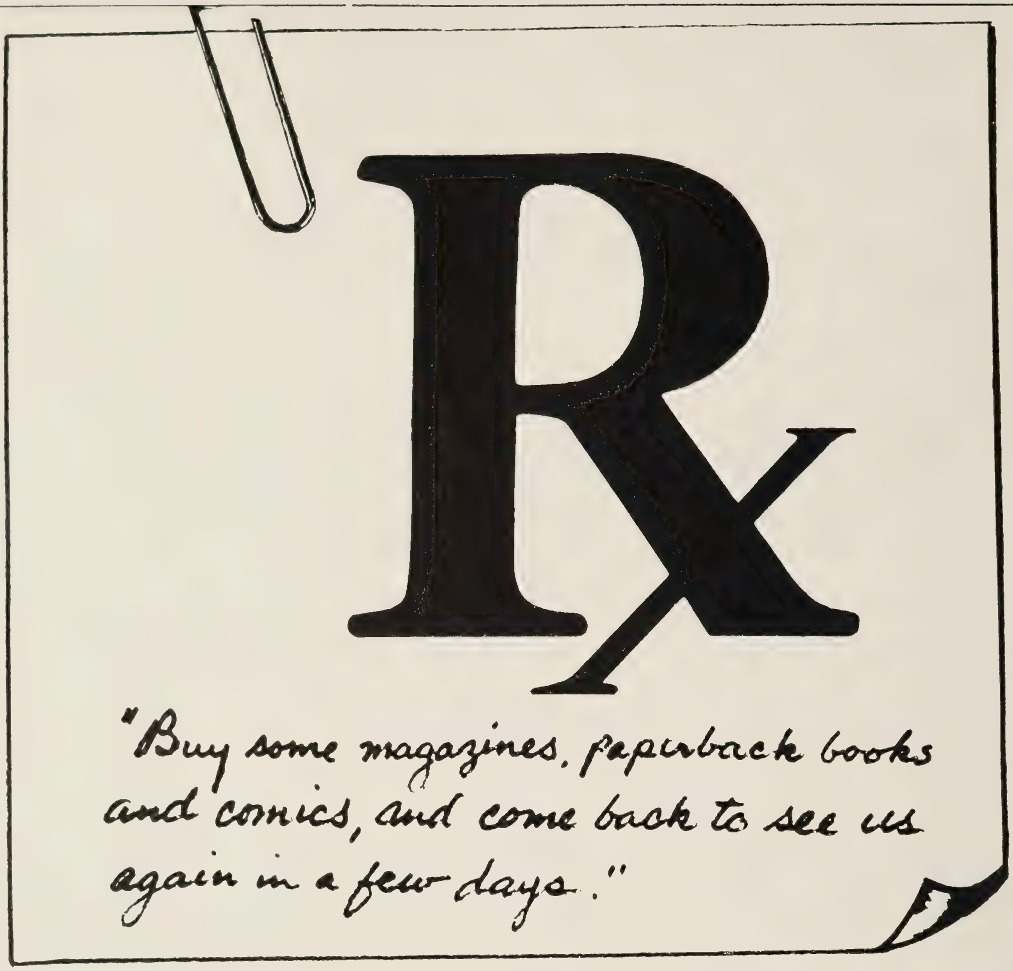

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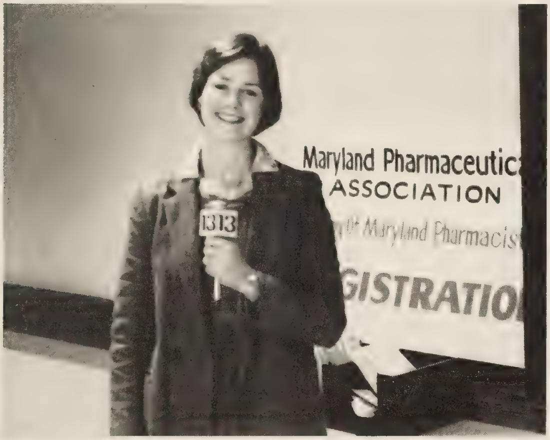
The Maryland Pharmaceutical

Rick Smith, representing the Eli Lilly Company, presents MPhA President Milton Sappe (right) with a special award on the occasion of the Association's Centennial Founding Day.



The press was invited to cover the seminar so that the public might have a better understanding of the factors involved with the rising cost of prescription drugs. Baltimore Channel 13 reporter Lisa Champo interviewed program participants.

The Fall Regional Meeting held on October 17 at the new School of Pharmacy Building featured a panel discussion on the rising cost of prescription drugs and its impact on the health care delivery system. Participating were; (left to right) Stanton Brown, Speaker of the House; Jay Rodgers, PMA Director of Marketing Analysis; Marion Friedman, representing the Medical Society; Paul Freiman, representing Pharmacy; and Stuart Baltimore, BC/BS Director of Pharmacy Programs.

A milestone in Maryland Pharmacy occurred on October 17, 1982 when Dean William J. Kinnard, Jr. presided over the dedication of the new School of Pharmacy located at 20 N. Pine Street in Baltimore. Nearly 1000 persons toured the building following dedication ceremonies and a block party.

Pictures courtesy Abe Bloom — District Photo

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What You Should Know About Commercial Armed Robbery

INTRODUCTION

Armed robbery is a dangerous crime that is on the increase in Maryland and throughout the nation.

It is defined as the unlawful taking of property from someone by using force or the threat of violence.

This booklet is designed to help retail managers and employees cope with this serious crime threat.

- It stresses what you can do ***before*** you are victimized to help ***prevent*** a robbery.
- It explains how the ***safety*** of customers and employees can be maintained ***during*** a robbery.
- And it details the steps you can take before, during and after a robbery to assist in the ***apprehension*** of the suspect.

By adopting common-sense security measures and by training your employees, you can **reduce the chance** that you will be robbed. And you'll **increase safety** in the event you are.

BEFORE: PREVENTION

A ***total*** security program is the best way to prevent armed robbery. Some of the following recommendations may not be possible in certain businesses. But the more of them you follow, the greater security image you will present. The stronger that security image is, the less likely the robber is to select your place as a target.

Visibility

Good visibility is important for two reasons. First, it allows employees to keep an eye out for any suspicious persons who may be lingering either outside or inside your business. And it increases the possibility that someone outside will observe a robbery if it does happen. Robbers don't like to be observed. So good visibility is a vital part of your prevention program.

Your front doors and windows should be kept clear of signs and posters to allow good, two-way visibility at your cash register area. Employees should be able to see out in order to spot suspicious persons who may be casing your place. And passers-by should be able to look in at your cash register area.

If you must post signs, place them to the side of the store's windows and either high enough or low enough to retain visibility.

The outside of your business and the parking lot should have enough lighting to provide visibility at night.

Interior lighting also should provide good visibility throughout your business.

The check-out stand and cash register should be located in a central position where it is clearly visible to observers outside.

Counters should be kept low enough so that employees can see customers throughout the business. If it's not possible to reduce the height of present shelves, you can at least stock only small merchandise items on the top shelf.

Special display racks and carousels should be positioned in such a way that they do not obscure visibility.

Special mirrors can be positioned in corners or other strategic spots to help employees monitor the entire business.

These suggestions will help prevent shoplifting, also!

Cash Control

Perhaps the strongest deterrent is to practice and advertise a cash-control policy. By keeping the lowest possible amount of cash on hand and letting everyone know it, you can reduce the attractiveness of your business as a robbery target.

Experience has shown that businesses can readily adjust to operating with less cash once a control policy is instituted.

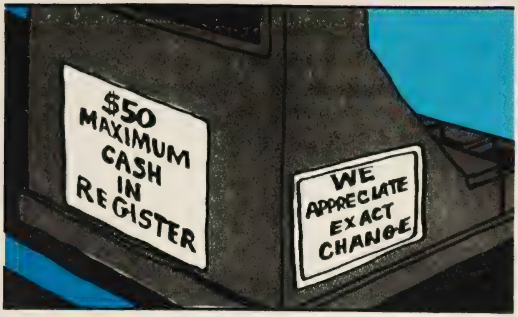
You should adopt a cash limit of, for example, $50. If a customer offers a large bill, the clerk will politely ask if he/she has anything smaller. Some stores, especially smaller ones, politely advise customers that they can't break a $20 bill (or anything larger than a $20) for a minor purchase, like a pack of cigarettes.

Employees then should be trained to check regularly for cash over that limit. Extra cash, especially large bills, should be placed in a safe, preferably a "drop safe," or a locked money chest.

Such a chest does not have to be burglary resistant since its purpose is to discourage the robber. It can be as simple as a steel box, bolted to a counter or wall, and locked.

Most law enforcement authorities recommend a safe which the clerk cannot open alone or one which requires two keys. That fact should be posted near the entrance or some other conspicuous place and on the safe itself.

If it is not possible to have a safe, don't place extra, large bills under the cash register till. Most robbers



know about that. If you don't have a safe, figure out the least obvious alternate place to hide your extra cash until it's time to go to the bank.

These cash-control measures don't help unless you post the fact that you practice them. Post a sign, such as "$50 Maximum Cash in Register," in a prominent place near your check-out stand and business entrance.

It's also a good idea to post a sign near the register, such as "We Appreciate Exact Change."

Banking

As an extension of a cash-control policy, you should deposit your money as often as is practical. This should never be less than daily and, preferably, should be more often.

Before you leave for the bank:

- Jot down the serial numbers of several of the larger bills as evidence in the event you are robbed.
- Look outside to see if any suspicious persons are lingering. If they are, call law enforcement and request a patrol check.

You should vary your banking routine. Carry your cash in a variety of ways, such as in a lunch sack, attaché case, flight bag, pocket, etc. If you leave with a bank money bag, you could be inviting a robbery en route.

Try to bank at different times of the day so that you don't set a pattern for someone who may be casing your place. It's also advisable to vary your route to the bank for the same reason. But always go to the bank directly, without making any other stops.

Alarms

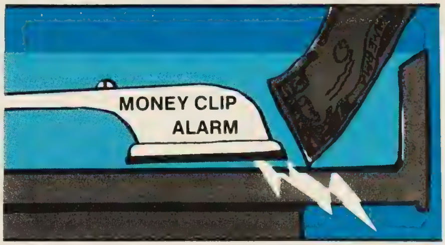
Another deterrent factor that will contribute to your total security image is to install an alarm and post the fact that you have one.

Alarms are available in a variety of price ranges. In choosing an alarm, it's best to get bids from three or more ***reputable*** firms, if possible.

The most important factor in alarm selection is the safety with which it can be activated. An alarm which requires a clerk to push a button, for example, is extremely difficult to use without arousing the robber's suspicion.

Perhaps one of the safest types of alarm is called a "bill trap" or "money clip." This type of alarm is installed in one slot of your cash drawer. The last bill in the slot serves as an insulator, but when it is removed in a robbery, the metal parts touch, activating the alarm. If you use a "money clip" alarm, it should be installed in the slot of one of the larger denominations—for example, the $10.00 slot.

Many law enforcement agencies have procedures for alarm verification and robbery response. It's advisable to find out what they are so that you'll know what to expect in the event of a robbery.



Suspicious Persons

All employees should be trained to be alert for suspicious persons. Remember, such observation will be more effective if you have good visibility both outside and inside.

Outside, parked cars and telephone booths are among favorite observation posts for casing a business.

Inside, clerks should be alert for "customers" who seem to be loitering or glancing around the store while appearing to shop or browse through a magazine.

Robbers don't like to be noticed or to have personal interaction. Therefore, it's a good idea for an employee to greet all entering customers politely, look them in the eye and ask if he/she can be of some help.

If a clerk spots a suspicious person either outside or inside, call law enforcement and ask for a patrol check.

For this reason, post your law enforcement agency's emergency telephone number on or near all of the phones in your business.

If you have a surveillance camera and the suspicious person is inside, it's a good idea to activate the camera for several frames. Such photos would be valuable evidence should the person return later for a robbery. (Your crime prevention officer can assist you in obtaining more information on surveillance cameras.)

Check References

A surprising number of armed robberies involve former employees. For that reason, authorities recommend that you screen applicants as carefully as possible before offering a job. Ask for and follow up on character references and, especially, former employers. A few phone calls may save you a variety of problems later on.

It's also a good idea to invest in an inexpensive camera. Take a snapshot of each new employee and keep it in the personnel file. (If you have an employee bulletin board, you can post the photo and an introductory welcoming note for a few days.)

A photo could help law enforcement identify a past employee who has come back to rob you. And the knowledge that such a picture exists just might discourage the potential robber.

Opening/Closing Times

Opening and closing times are especially vulnerable times for robberies. If at all possible, have two persons on hand at both times.

At opening time, one person should enter the business to check to see if it has been disturbed overnight. A second person should wait in an inconspicuous location outside the business until receiving a pre-arranged "all clear" signal from the person inside.

Before closing, check the office, back rooms, rest rooms and other areas to make sure no one is hiding there.

Side/Back Doors

If possible, side or back doors should be kept locked at all times to prevent a potential robber from entering undetected. Ask employees to use the main entrance to avoid the chance that a back door will be left unlocked accidentally.

Storage Rooms

Robbers sometimes lock employees in storage rooms. Therefore, it is advisable to install a lock that can be opened from the inside and to keep an extra key there.

For the same reason, if you have an alarm, consider installing a button in the back room.

Weapons

It may occur to you to keep a weapon at the business. Virtually all authorities strongly recommend against it. The chances of injury . . . or worse . . . are just too great.

Credibility

Don't be tempted to use phony signs or equipment. The use of a phony surveillance camera, for example, can destroy the credibility of all of your other security precautions.

BEFORE: IDENTIFICATION

Here are two simple steps you can take at no cost to help in the apprehension and conviction of a suspect.

Bait Money

Take several dollar bills and write down their serial numbers. Keep the record in a safe place. Then place these recorded bills at the bottom of a till section holding one of the larger denominations—for example, under the $10 bills.

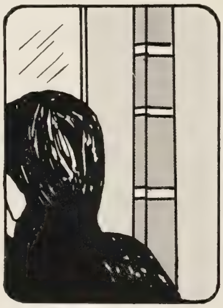
Don't use the bait money for normal transactions. But, of course, it should be given to a robber along with other money. It's a good practice to change the bait money from time to time.

Your record of the serial numbers could help track the robber and will be proof that the money was stolen from you.

Height Markings

Place markers at the main entrance to help employees to gauge the height of a robber as he leaves your business.

All you'll need is a few pieces of one-inch wide colored tape. Place tape in strips about an inch high at the 5′, 5′6″ and 6′ heights. Vary the color of the middle tape; so that there is no confusion.



DURING: SAFETY

Even with a strong security program, there is some chance that a robbery will occur.

Robbery is a potentially explosive confrontation. Yet most robberies take less than two or three minutes. It's imperative that everyone involved in a retail operation be taught how to react in that short period of time in a way that will promote the safety of employees and customers.

Your employee training should include involving personnel in a "mock" robbery.

The Employee

The employee should be trained to act according to these time-tested recommendations:

- Be as polite and accommodating as possible under these trying circumstances.
- Don't appear to be stalling. Convey by actions and/or words that you will cooperate.

- Do *exactly* what the robber asks. If he asks for tens and twenties, for example, give him those only.
- Tell him in advance if you need to make any move, especially one he doesn't expect. If he wants the money in a bag and you have to reach below to get one, tell him what you are going to do.
- Do not try to use an alarm, especially of the hand- or foot-activated type, unless you can do so safely without any obvious movement which might cause the robber to react in panic.

The Robber

The robber is likely to be a young male. In many cases, he will be armed with a deadly weapon.

The robber will be a bundle of nerves. He is likely to react even more aggressively to any act which comes as a surprise or appears threatening.

All law enforcement experts agree: ***This is no time for impulsive heroics.*** Your percentages are not good. The stakes are not worth serious injury or death. Money can be replaced, a life cannot!

Once a robbery begins, there is only one mission: ***maintain safety until the robber leaves.***

DURING: IDENTIFICATION

While the primary concern should be to follow these safety suggestions, employees also should be aware of what they can do to help identify the robber.

Demand Note

Any note which the robber might give could be valuable for handwriting and fingerprint evidence. Try to slide any note out of the robber's reach in a casual way, handling it as little as possible.

Suspect ID

Try to observe the robber in as normal a way as possible, without staring obviously.

The more you can remember, the more helpful it will be to law enforcement. The most important points: color of hair, eyes and skin . . . facial features . . . approximate age, height and build . . . any unusual markings (scars, tattoos, etc.) . . . mannerisms or speech peculiarities or accents . . . jewelry . . . clothing.

Physical features and mannerisms are more important than clothing because the latter can be changed or discarded, especially caps or jackets. Jewelry is less likely to be discarded.

A suspect identity chart appears on page 24. You can make photocopies of that chart and keep them near the check-out stand for later reference.

Weapon ID

Although information about weapons is helpful to law enforcement, it is not practical to train employees in technical detail.

However, anything they can remember about the weapons would be useful. Also try to note in which hand the robber is holding the weapon.

The most prevalent weapons are handguns. There are two basic types:

Revolver: The distinguishing feature is a cylinder in the middle which revolves to put the bullets into position.

Automatic: These are flat-sided—no cylinder. The bullet clip is in the grip, where you can't see it.

Rifles and shotguns also are used in robberies. The shorter, sawed-off variety of shotgun often is used.

If any type of rifle or shotgun is used, it is most important to tell the police so that they can make safety considerations in pursuit and apprehension.

Bear in mind that just because you can't see a weapon doesn't mean that the robber doesn't have one concealed.

Departure

As the robber is leaving, continue to obey his directions exactly until you know he is out of the business. Do **not** try to follow him.

AGAIN, IT CANNOT BE EMPHASIZED ENOUGH TO COOPERATE AT ALL TIMES WITH THE ROBBER. YOUR PRIMARY CONCERN IS TO BECOME A *SUCCESSFUL VICTIM*—ONE WHO HAS GOTTEN THROUGH THE SITUATION UNHARMED.

AFTER: EVIDENCE AND IDENTIFICATION

1. Once the robber is outside, try to watch through the window. Try to note the type of get-away vehicle, whether or not there were any accomplices and the direction of escape. If it is possible to see the vehicle's license number, write it down. (Once again, the visibility factor is important.) Close the business and lock the door if at all possible.

2. Then call law enforcement ***immediately,*** using the emergency number posted by the telephone. Do this even if you already have activated an alarm.

State your name, address and telephone number and what happened. ***Stay on the line*** until they tell you to hang up.

3. Do not discuss details of the robbery with fellow employees, witnesses or anyone else. Ask any witnesses to stay until police arrive. While they wait, encourage them to write down what they remember. If they can't stay, get their names and addresses so police can reach them later.

4. Next, try to protect any fingerprints or other evidence. Use a box, bag or anything else handy to cover or block off any merchandise, counter area or door handle which the robber may have touched. Don't touch those things yourself.

SUSPECT ID CHART

(Use this page to make photo copies for your employees)

SEX	RACE	AGE	HEIGHT	WEIGHT

HAIR

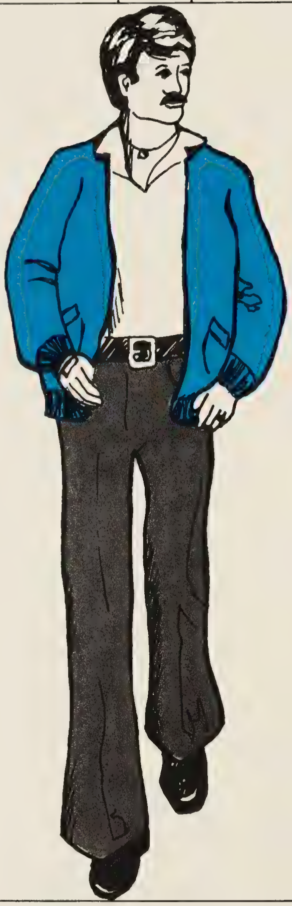
EYES

GLASSES TYPE

TATTOOS

SCARS/MARKS

COMPLEXION



HAT (COLOR, TYPE)

TIE

COAT

SHIRT

TROUSERS

SHOES

BAIT MONEY SERIAL NUMBER

AUTOMOBILE DESCRIPTION
(LICENSE NUMBER, MAKE, COLOR)

STAY ON THE PHONE!

Clip and post

5. Try to recall as much as you can about the robber's appearance, speech and mannerisms. It's best to make notes on these points as soon as possible. Investigating officers will know what to ask you. Use your notes to help answer their questions as fully as possible.

6. Obtain the recorded serial numbers of your bait money and give to the officer.

Let the police answer any inquiries from the news media. do not discuss the amount of money taken with anyone except law enforcement. ***Ask investigating officers to keep the amount of money confidential.***

NOW IT'S UP TO YOU!

This book is a part of Maryland's State-wide crime prevention effort known as Maryland crime Watch.

For additional information, please contact:

Maryland Crime Watch
Suite 700, One Investment Place
Towson, Maryland 21204
Phone:)301) 321-3636

Get Ready for Poison Week

This year's Maryland Poison Prevention Week—83 (March 20–26, 1983) will focus on the "warning signal" words used on product labels. A poster and handout explaining what these signal words are and what they mean in terms of toxicity is currently being developed by the Maryland Poison Center for use in pharmacy, hospital, and Health Fair-83 sites. A packet of materials for use in MPPW-83 will be available at minimal charge for postage and handling in mid-February. Additional materials will be available at cost.

Again this year the Maryland Poison Center urges pharmacists, especially preceptors, to actively promote MPPW-83 poison prevention activities in any way—poster contests, displays, presentations to the community, etc. Syrup of ipecac will again be stressed as the major medicine to have in case of a poisoning. Copies of last year's poster on Syrup of ipecac "Mr. Yuk saves lives . . . Syrup of ipecac can too" are still available from the center.

If you are interested in participating in Maryland Poison Prevention Week—83, please contact Jacquie Lucy, MPC education coordinator, at (301) 528-7184. An order form and sample of the handout should appear in the January issue of the *Maryland Pharmacist*.

LETTERS

Dear Mr. Banta:

I very much appreciate the old prescription and apothecary jar which you so thoughtfully presented to me on September 28, 1982. I was pleased to proclaim "Maryland Pharmaceutical Association Founding Day" and am glad that you were able to join me for the proclamation ceremony.

You have my best wishes.

Sincerely,
Harry Hughes
Governor

Dear Dave Banta:

I sure miss you wonderful men there. Convey my best wishes to them and hopefully I may get back there, I love it so very much.

I read over all the materials you mail me from cover to cover and keep my Md. license current with much pride.

Say Hello to the Eastern Shore group—a wonderful great group.

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Sincerely
Vince Gattone

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ABSTRACTS

Excerpted from PHARMACEUTICAL TRENDS, published by the St. Louis College of Pharmacy; Byron A. Barnes, Ph.D., Editor and Leonard L. Naeger, Ph.D., Associate Editor

SALMONELLA:

Salmonella is one of the most common pathogens found in contaminated food. When outbreaks occur, investigators try to find a common source of the poisoning in order to prevent further problems. Recent outbreaks in Ohio, Michigan, Georgia, and Alabama have been found to be associated with contaminated marijuana. The organism isolated from the plant material contains two low molecular weight plasmids not found in other strains of Salmonella. *N Engl J Med,* Vol. 306, #21, p. 1249, 1982.

HYDRALAZINE:

Patient compliance is lessened as the number of doses required per day increases. Efforts have been made to study drugs which require frequent administration to see if larger doses might be given less frequently without sacrificing efficacy or increasing toxicity. Hypertensive patients receiving hydralazine have been examined and investigators have concluded that adequate blood pressure control can be achieved if the drug is taken twice daily. *Br Med J,* Vol. 284, #6329, p. 1602, 1982.

ORAL CONTRACEPTIVES:

The incidence of ovarian cancer in women was studied in approximately 136 patients. Results of the study indicate that women taking combination oral contraceptives experience fewer neoplastic growths than do those not taking the medication. Some researchers feel these preparations may help protect against the development of ovarian cancer. *J Am Med Assoc,* Vol. 247, #23, p. 3210, 1982.

INDOMETHACIN-MORPHINE COMBINATION:

A prospective randomized trial was undertaken to assess the combination of indomethacin (Indocin) and morphine to relieve discomfort in post-surgical patients. Patients who received the anti-inflammatory agent required fewer doses of the narcotic than did those not receiving the indomethacin. It seems logical to use anti-inflammatory agents in conjunction with narcotics in post-surgical patients. *Lancet,* Vol. II, #8290, p. 115, 1982.

HOT TUBS:

Occasionally an outbreak of cutaneous Pseudomonas aeruginosa occurs in people who have shared hot tubs. The eruptions generally occur in areas covered by the swimming suit and appear within 8 to 48 hours after exposure. This can be prevented by keeping the pH of the water between 7.2 and 7.4 and by keeping chlorine levels between 0.4 and 1.0 ppm. *Am J Dis Child,* p. 553, June, 1982.

TRAVELERS DIARRHEA:

Approximately half of the Americans visiting foreign countries will experience diarrhea which can be uncomfortable, debilitating, and sometimes very dangerous. Since Escherichia coli toxin is the most common cause of this condition, a vaccine is being readied for clinical trials which may be useful in preventing the development of these symptoms. The vaccine will act to reduce the ability of the organism to adhere to the cells of the intestinal lining and thus they will pass harmlessly from the body without causing toxicity. *J Am Med Assoc,* Vol. 247, #24, p. 3295, 1982.

INSULIN PUMPS:

After several years of refinements, insulin pumps are now of such size that they can be implanted into the left subclavian fossa. Patients with insulin dependent diabetes mellitus (Type II hyperglycemia) achieve good blood glucose control with those infusion pumps and thus investigators feel these devices can be used with confidence in patients requiring insulin to control their symptoms. *N Engl J Med,* Vol. 307, #5, p. 265, 1982.

COLONIC IRRIGATION:

Irrigation of the colon using a series of enemas in a short time frame has been used by some practitioners of homeopathy, naturopathy, chiropractic, and nutritional therapy. At one time, this was considered a harmless procedure, but deaths due to electrolyte disturbances, bowel perforation and necrosis and toxic colitis have occurred following the procedure. A recent outbreak of amebiasis was traced to a contaminated apparatus used for this procedure. *N Engl J Med,* Vol. 307, #6, p. 339, 1982.

ASPIRIN:

Studies using low dose aspirin seem to show the antiaggregation effect of the salicylate can be produced at very los dosing regimens. Higher doses interfere with prostaglandin synthesis in other parts of the body and thus the effect is lessened. The dose used in this study was 0.45 mg/kg/day which is equivalent to approximately 30 mg/day for the average adult. *J Clin Invest,* Vol. 69, #6, p. 1366, 1982.

FUROSEMIDE:

Thiazide diuretics cause calcium retention while loop diuretics cause calcium to be lost. Studies suggest that calcium absorption in the loop of Henle is inhibited by the loop diuretic and thus calcium excretion is increased. *J Pharmacol Exp Ther,* Vol. 221, #3, p. 815, 1982.

ANTIDEPRESSANTS:

Generally the combination of a monoamine oxidase inhibitor and a tricyclic antidepressant is not recommended, but a group in Great Britain have used the combination to prevent the "cheese" reaction seen when some people taking monoamine oxidase inhibitors alone ingest the dairy product. Cheese contains tyramine, an indirect acting adrenergic agent which can increase blood pressure, cause headaches, and induce a hypertensive crisis. Since tricyclic antidepressants prevent neuronal uptake of norepinephrine, and since tyramine and norepinephrine are structurally similar, amitriptyline (Elavil) was administered along with the monoamine oxidase inhibitor to patients who experienced the cheese reaction while taking the enzyme inhibitor alone. These patients tolerated the cheese ingestion with the combination therapy. Since monoamine oxidase inhibitors do allow for the accumulation of tyramine in the plasma, ingestion of foods which contain the amine should be avoided even in patients receiving combination therapy. *Lancet,* Vol. II, #8291, p. 183, 1982.

MORPHINE:

Post-surgical patients were given standard doses of morphine (10 mg if they weighed less than 70 Kg and 15 mg if they weighed more) intramuscularly and the results of this injection compared to those received in patients who had taken morphine orally in a sustained release tablet form. The oral form was administered in doses which were exactly double those used via the injectable route. Oral formulations produced satisfactory pain relief when compared to the injections and therefore this may be a way to avoid injecting drugs if the patient can tolerate oral medication. *Br Med J,* Vol. 285, #6335, p. 92, 1982.

PLATELET ACTIVITY:

Platelet metabolism had been intensively investigated over the past several years and a substance called calmodulin seems to play a major role in the activation of platelet enzymatic activity. Calmodulin probably mediates calcium control of several biochemical processes in the platelet and thus deserves further study. Another substance found to play a role in platelet activity is gelsolin. *J Clin Invest,* Vol. 69, #6, p. 1348, p. 1384, 1982.

ALCOHOL AND CONGESTIVE HEART FAILURE:

Patients with congestive heart failure were given various doses of ethanol in the form of vodka and their cardiac function monitored closely. No changes were seen in cardiac function or performance and thus occasional consumption of moderate amounts of alcohol can safely be tolerated in patients treated for congestive heart failure. *Ann Intern Med,* Vol. 97 #2, p. 171, 1982.

CALCIUM:

Patients with hypertension are noted to have several types of metabolic disturbances, including hypocalcemia. A study of normal and hypertensive patients has indicated that the serum ionized calcium concentration in hypertensive patients is lower than that found in normotensive volunteers. Further investigation will try to determine if calcium has a role in the production of essential hypertension. *N Engl J Med,* Vol. 307, #4, p. 226, 1982.

URIC ACID AND DIABETES:

A prospective study of diabetes in 10,000 men over the age of 40 years has yielded some unexpected results. It seems that those men with a predisposition for diabetes mellitus have elevated levels of plasma uric acid when compared to normal controls. No explanation for the rise is known but it may be a useful tool in screening patients who may have a greater likelihood of developing diabetes mellitus. *Lancet,* Vol. II, #8292, p. 240, 1982.

MINOXOLONE:

A new water-soluble steroidal anesthetic has been used intravenously for periods as long as three hours. The distribution of the drug is rapid, and the half-life is short. Minoxolone may be suitable for use by intravenous infusion. Support for investigation of this drug is being supplied by Glaxo Canada Limited. *J Clin Pharmacol,* Vol. 22, #7, p. 161, 1982.

THROMBOXANE:

Thromboxane A-2 is a potent endogenous platelet aggregator which is decomposed to form thromboxane B-2, an inactive metabolite. Patients dying with septic shock have been found to have ten times more thromboxane B-2 in their plasma than do patients who survive this potentially fatal condition or in normal volunteers. Investigators are trying to determine if thromboxane contributes to the respiratory distress syndrome and disseminated intravascular coagulation which is associated with severe sepsis. *Lancet,* Vol. II, #8291, p. 174, 1982.

PERSONALITY CHANGES:

The type A personality is one characterized by hard working, aggressive behavior. This group of people have a high incidence of hypertension and coronary heart disease and thus are frequently treated with beta-adrenergic blocking agents. Physicians have found that after taking these drugs for a period of time there is a tendency for the person to experience a personality change toward the type B personality, a less aggressive type. Beta-adrenergic blocking agents cross the blood brain barrier and thus may be responsible for this personality shift. *J Am Med Assoc,* Vol. 247, #20, p. 2759, 1982.

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- March 13 "Communication and the Elderly" Center for Aging MPhA Seminar
- March 27 "Arthritis"—CECC Seminar
- June 18–30 MSHP Annual Seminar—Atlantic City
- June 26–30 MPhA CONVENTION IN OCEAN CITY—year 101

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